

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6010

## CERTIFICATE OF DEATH

Reg. Dist. No. 05987

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md				c. LENGTH OF STAY IN 1b 2 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville, Md.				d. STREET ADDRESS 7302 Wells Blvd			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary E Allen				4. DATE OF DEATH Month Day Year May 8 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-16-02	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME John M Mc Carthy				14. MOTHER'S MAIDEN NAME Mary J. Clements			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Frank H Allen Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538 Acute pyelonephritis & abscess DUE TO (b) Adenocarcinoma of the colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1, 1957, to May 8, 1958, that I last saw the deceased alive on May 8, 1958, and that death occurred at 10:55 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE T. Bergman M.D.							
PHYSICIAN'S NAME (Type) Dr. T. Bergman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 10, 1958		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE MAY 12 '58	
						24b. REGISTRAR'S SIGNATURE W. Leach	

MEDICAL CERTIFICATION

TO HOSPITAL OR A NURSING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—BALTIMORE 18

2.4.2. *Environ*

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05988

Reg. Dist. No.

6979

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>	c. LENGTH OF STAY IN 1b <u>30 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8001 Marlboro Pike SE</u>		d. STREET ADDRESS <u>18001 Marlboro Pike</u>	
3. NAME OF DECEASED (Type or print) <u>Royce Cleveland Arnold</u>		4. DATE OF DEATH <u>May 25 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> Days <u>Hours</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edgar Arnold</u>		14. MOTHER'S MAIDEN NAME <u>Ella May Frye</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary Richardson, Meadows, Hy</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c) <u>stating the underlying cause last.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>May 25, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 28-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Edgar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>St. Landry La.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>		24. REG. BY REGISTRAR <u>W.D. Deuch</u>	
ADDRESS <u>1661-gd Hope Rd SE</u>		DATE <u>MAY 27 '58</u>	





TO HOSPITAL OR TO FUNERAL DIRECTOR. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6080

## CERTIFICATE OF DEATH

Reg. Dist. No.

05989

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE _____ b. COUNTY <u>Washington, D.C.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andrews A.F. Base</u>				c. LENGTH OF STAY IN 1b <u>8 DAYS</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1001ST USAF HOSPITAL</u>				d. STREET ADDRESS <u>47 SEATON PL. N.W.</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>CELESTINE BARINO</u>				4. DATE OF DEATH Month Day Year <u>MAY 19 1958</u>					
5. SEX <u>FEM</u>		6. COLOR OR RACE <u>NEG</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 2, 1914</u>			
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC WORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE HOME</u>					
11. BIRTHPLACE (State or foreign country) <u>SOUTH CAROLINA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>CHARLIE HOWARD</u>				14. MOTHER'S MAIDEN NAME <u>KATIE UNKNOWN</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>249-10-9241</u>					
17. INFORMANT <u>JOHNNY BARINO</u> Address <u>SON</u>				47 SEATON PL. N.W. WASH D.C.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC DECOMPENSATION</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> <u>6 mos</u> DUE TO (c) <u>CHRONIC PYELONEPHRITIS INTERVALS</u> <u>UNKNOWN</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____									
21. I certify that I attended the deceased from <u>MAY 12</u> , 19 <u>58</u> , to <u>MAY 19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MAY 19</u> , 19 <u>58</u> , and that death occurred at <u>10:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>MAY 19, 1958</u> DATE SIGNED ACTUAL SIGNATURE <u>Edward J. Smith</u> M.D. <u>Andrews A.F.B., Wash D.C.</u> PHYSICIAN'S NAME (Type) <u>EDWARD J. SMITH CAPT USAF(MC) 1001ST USAF Hospital</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>24 MAY '58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>JACKSON CEMETARY</u>		22d. LOCATION (City, town, or county) (State) <u>MARION, S. CAR.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHNSON &amp; JENKINS</u>				ADDRESS <u>4804 GA. AVE. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>MAY 23 '58</u>			
				24b. REGISTRAR'S SIGNATURE <u>Quel...</u>					

14 MAY 1958: I the undersigned, do hereby certify that this death was reported to the Medical Examiner, Prince Georges County (Dr J. Boyd) and that said Medical Examiner authorized movement of remains from Andrews A. F. Base to Bolling AFBase for purpose of autopsy and further authorized movement of remains to a mortuary of families choice. (Johnson & Jenkins Funeral Home in Wash D.C.)

Paul R Nowatil  
Registrar

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05990

Reg. Dist. No.

6011

FOR STATE  
HEALTH DEPT.

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I

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Seland Memorial Hosp.		e. STREET ADDRESS 4515 - Buchanan St	
3. NAME OF DECEASED (Type or print) Allen Leon Bean		4. DATE OF DEATH May 25 - 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-04
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		11b. KIND OF BUSINESS OR INDUSTRY Painting	
12. BIRTHPLACE (State or foreign country) S. Carolina		13. CITIZEN OF WHAT COUNTRY U.S.A	
14. FATHER'S NAME Daniel Bean		15. MOTHER'S MAIDEN NAME Ida Mally	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		17. SOCIAL SECURITY NO. 579-07-9441	
18. INFORMANT Ruth E. Bean, Same address		19. ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Gentle congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to the immediate cause (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN T. MALONEY, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		5-25-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/27/58	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE MAY 26 '58			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BOX 21A  
DEATH CERT.



NEW YORK STATE DEPARTMENT OF HEALTH - BATHING 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Faint, mostly illegible handwritten text and printed form fields are visible. The form appears to be a standard medical certificate with sections for patient information, cause of death, and examiner details.]*

6781

CERTIFICATE OF DEATH

Reg. Dist. No. 05991

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geos Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Seat Pleasant</u>		c. LENGTH OF STAY IN 1b <u>9 Yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) x Seat Pleasant Md</u>		d. STREET ADDRESS <u>7979 Walker Mill Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rebecca Anne Berry</u>		4. DATE OF DEATH Month Day Year <u>May 20 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1863 95</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Richard Dunkin</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>7979 Walker Mill Rd SE Washington 28 D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>9 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Asthma</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 15</u> , 19 <u>49</u> , to <u>May 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>58</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Suit Ritchie</u> M.D.		ADDRESS (Street, city or town, state) <u>7005 Ritchie TR SE Wash 27 D.C.</u>	
PHYSICIAN'S NAME (Type) <u>W. Suit Ritchie</u>		DATE SIGNED <u>5/20/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>May 24, 1958 St. Mary's M.E. Church, Croome, Md.</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jerry S. Washington &amp; Sons - 467-7-774</u>		24a. REC'D BY REGISTRAR <u>MAY 23 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. S. Ritchie</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05992

6012

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>16 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gilbert Simpson Bigelow</b>		4. DATE OF DEATH Month Day Year <b>May 6, 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-26-21</b>
9. AGE (In years last birthday) <b>36</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ulysses S. Bigelow</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Wright</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W.W. 2</b>		16. SOCIAL SECURITY NO. <b>579-18-7681</b>	
17. INFORMANT Address <b>Silastine Bigelow; 1318 22nd St. N.W. Wash., D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral contusion and compression</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Intracranial hemorrhage</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Lost control of motor cycle and throw to road.</b>	
20c. TIME OF INJURY Month, Day, Year <b>11-55 a.m. 4-20- 58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) <b>Glen Dale, Pr. Geo. Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 7, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>May 7, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat.</b>		22d. LOCATION (City, town, or county) <b>Arlington</b> (State) <b>Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gersch's Sons</b> ADDRESS <b>4739 Balt. Ave Hyattsville Md</b>		24a. REC'D BY REGISTRAR <b>W. Beach</b> DATE <b>MAY 12 '58</b>	
		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEGALOCALAMUS, 1971

44

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6013

## CERTIFICATE OF DEATH

05993

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>23 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>J.</b> Last <b>Boege</b>		4. DATE OF DEATH Month <b>May</b> Day <b>4</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>13 April 1888</b>
9. AGE (In years last birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Johann</b>		14. MOTHER'S MAIDEN NAME <b>Fredrika ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Anna Marie Boege</b>	
17. INFORMANT <b>above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Congestion &amp; Toxicemia</b> DUE TO <b>151X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the stomach</b> DUE TO <b>Infarction of the stomach</b> (c) <b>Infarction of the stomach</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>40 hours</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10-11</b> , 19 <b>58</b> , to <b>5-4</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5-4</b> , 19 <b>58</b> , and that death occurred at <b>7:20A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Samuel Schwartzbach</b> M.D. <b>1226 Eye St. N.W.</b> PHYSICIAN'S NAME (Type) <b>SAMUEL SCHWARTZBACH</b> <b>Wash., D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/6/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fork Lane Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cremar Manor, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home, Inc.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 8 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF HEALTH - BETHESDA, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6714 Item 7 Film G230 6-16-58 et  
CERTIFICATE OF DEATH

Reg. Dist. No. 05994

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hosp.		d. STREET ADDRESS 4401-28th Place	
3. NAME OF DECEASED (Type or print) Nellie J. Borland		4. DATE OF DEATH Month 5 - Day 7 - Year 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/25/72
9. AGE (In years 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Effingham, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Hilson		14. MOTHER'S MAIDEN NAME Sarah Arnold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Margaret Lamb - Daughter		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X C. U. A. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5-6-58	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 - 3, 1955, to 5-7, 1958, that I last saw the deceased alive on 5-7, 1958, and that death occurred at 6:55 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George H. George, M.D. 3717-38th Ave. Prince Georges, Md. 5-7-58 ACTUAL SIGNATURE George H. George, M.D. FUNERAL DIRECTOR'S NAME (Type) George H. George, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/10/58	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colman Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc.		ADDRESS Mt Rainier, Md.	
24a. REC'D BY REGISTRAR DATE MAY 12 '58		24b. REGISTRAR'S SIGNATURE	



1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05995**

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillside</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillside</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1207 54th Avenue</b>		d. STREET ADDRESS <b>1207 54th Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Clarence</b>		4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1907</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Skilled</b>	
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Clarence Marshall Bradenburg</b>		14. MOTHER'S MAIDEN NAME <b>Estella May White</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes no</b>		16. SOCIAL SECURITY NO. <b>577-09-6145</b>	
17. INFORMANT <b>Mrs Janet Brandenburg,</b>		Address <b>same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO (b) <b>Cardiovascular renal disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		DATE SIGNED <b>May 15, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>5/17/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Company</b>		24a. REC'D BY REGISTRAR <b>2901 14th St. N.W. Washington 9, D.C.</b>	24b. REGISTRAR'S SIGNATURE <b>DATE MAY 19 '58</b>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.



STATE OF CALIFORNIA

10. The undersigned, being a duly qualified physician, do hereby certify that the within and above named person died on the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_, at \_\_\_\_\_, California, of \_\_\_\_\_, and that the death was caused by \_\_\_\_\_, and that the death was not caused by any other cause than that stated above.

0032

STATE DEPARTMENT OF HEALTH - CALIFORNIA 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05996**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph</b> First <b>Matterson</b> Middle <b>Bridgehouse</b> Last		4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-9-1896</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Supt. of Cemeteries</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Bridgehouse</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Daly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>15-16-7712</b>	
17. INFORMANT <b>Josephine Shenski; same address as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary abscess</b> DUE TO (c) <b>Pneumonitis</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiovascular renal disease</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>May 12, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>5/12/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Swimberg Funeral Home</b>	22d. LOCATION (City, town, or county) (State) <b>Egg Harbor New Jersey</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gaschinsome Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 14 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Robert Smith</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by filing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MAY AND STATE DEPARTMENT OF HEALTH - BATHING IN MAY EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]	
MARITAL STATUS [Illegible]		PREVIOUS ILLNESS [Illegible]	
SIGNATURE OF EXAMINER [Illegible]		OFFICIAL SEAL [Illegible]	

- 1 -

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6916

Items 1-8 Film 230 6-12-58 et

## CERTIFICATE OF DEATH

05997

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>99 Pri. Geo. Gen. Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lakeland</b> d. STREET ADDRESS <b>5105 Navahoe</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Cager</b> <b>Fannie</b> <b>Rebecca</b>		<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>22</b> Year <b>1958</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Jan 1-1894 1895</b> <b>63 yrs.</b>
<b>9. AGE</b> (In years last birthday) <b>63 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Domestic</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>John Williams</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Minnie Johnson</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> Address
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> DUE TO <b>Congestive Ah failure</b> <b>Arterio sclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. 19	
<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that I attended the deceased from</b> 19 to 19, that I last saw the deceased alive on May 22, 1958, and that death occurred at 9:15 A. M. from the causes and on the date stated above.	
<b>ACTUAL SIGNATURE</b> <b>Dr. Walcott Etienne</b>		<b>ADDRESS</b> (Street, city or town, state) <b>4713 - Berwyn Rd</b> <b>College Park, Md</b> <b>DATE SIGNED</b> <b>4/22/58</b>	
<b>PHYSICIAN'S NAME</b> (Type) <b>Dr. Walcott Etienne</b>		<b>22a. BURIAL, CREMATION, REINTERMENT</b> <b>BURIAL</b>	
<b>22b. DATE THEREOF</b> <b>5/26/58</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Bacontown,</b>	
<b>22d. LOCATION</b> (City, town, or county) (State) <b>Bacontown, Md.</b>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert L. Snowden</b>	
<b>ADDRESS</b> <b>Rockville, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>MAY 27 1958</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Overman</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Medical Examiner Notified - Released  
 1  
 2



CERTIFICATE OF DEATH

Form No. 10

DECEASED  
Name  
Age  
Sex  
Race

Residence

Place of Birth

Married

Occupation

Age

Sex

Race

Religion

Married

Place of Birth

Place of Death

Cause of Death

Signature of Physician

Signature of Registrar

Date

Signature of Physician

Signature of Registrar

Date

Signature of Physician

Signature of Registrar

Date

Signature of Physician

Signature of Registrar

Date

Signature of Physician

Signature of Registrar

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Signature of Physician

Signature of Registrar

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Signature of Physician

Signature of Registrar

Date

Signature of Physician

Signature of Registrar

Date

Signature of Physician

Signature of Registrar

Date

Signature of Physician

Signature of Registrar

Date



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G229, 5/26/58 fcy

CERTIFICATE OF DEATH

05998

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>9 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville,</b> d. STREET ADDRESS <b>4308 Hamilton St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Sydney Carroll Jr</b>		4. DATE OF DEATH Month Day Year <b>May 14, 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-3-11</b>
9. AGE (In years lost birthday) <b>46</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical supplies</b>	
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Sydney Carroll Sr</b>		14. MOTHER'S MAIDEN NAME <b>Mina Espey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W W 11</b>	
17. INFORMANT <b>Mina Carroll</b>		Address <b>Hyattsville Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>393.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>+ Bronchopneumonia left lower lobe</b> DUE TO (c) <b>Chronic Pericardial heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-4</b> , 19 <b>58</b> , to <b>5-15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5-14</b> , 19 <b>58</b> , and that death occurred at <b>11:52 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hyattsville Md</b> DATE SIGNED <b>5-15-58</b>			
ACTUAL SIGNATURE <b>Dr. Aaron Deitz</b>		M.D. <b>Hyattsville Md</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Aaron Deitz</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 20, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 21 '58</b>		DATE <b>MAY 21 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>			

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

EDUCATION

RELIGION

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

STATE OF MARYLAND

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICE, CITY OF BALTIMORE, MD.

## 6018 CERTIFICATE OF DEATH

Reg. Dist. No. 55999

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Eugene Island Memorial</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Seat Pleasant</u>			
f. STREET ADDRESS <u>6902 George Palmer Highway</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Max</u> Last <u>Carwile</u>				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-96</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Wesley Roach</u>				14. MOTHER'S/MAIDEN NAME <u>Susie Hammett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Husband - Hosp. Chart.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> 153.8 DUE TO <u>with metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 yr</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 29, 1958</u> , to <u>May 2, 1958</u> , that I last saw the deceased alive on <u>May 2, 1958</u> , and that death occurred at <u>5:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L W Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale, Md 20854</u>			
PHYSICIAN'S NAME (Type) <u>L W Malin MD</u>				DATE SIGNED <u>May 5-2-58</u>			
22a. BURIAL, CREMATION, or other disposition (Specify) <u>2901-14 St. NW</u>		22b. DATE THEREOF <u>5/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Homestead</u>		22d. LOCATION (City, town, or county) (State) <u>Charlotte County, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S.H. Hines Co.</u> ADDRESS <u>2901-14 St. NW, Wash D.C.</u>				24a. RECEIVED BY REGISTRAR <u>5-5-58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8202

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06000

5997

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>CARROLL MANOR REST HOME</b>				d. STREET ADDRESS <b>2126 CONN. AVENUE, N.W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MARTHA</b> Middle <b>BUTLER</b> Last <b>CHANCELLOR</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>8</b> Year <b>19 58</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 6, 1874</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>CHARLES WILLIAMS CHANCELLOR</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA ANN BUTLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>DALE D. DRAIN, 1405 "G" STREET, N.W., D.C.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis General</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>21 days</b> <b>15 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 18, 19 58</b> to <b>May 8, 19 58</b> that I last saw the deceased alive on <b>May 7, 19 58</b> , and that death occurred at <b>12:05 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>322 H Street NE</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Thomas F Collins M.D.</b>				M.D. <b>322 H Street NE</b>			
PHYSICIAN'S NAME (Type) <b>Thomas F Collins M.D.</b>				<b>Washington DC</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5-12-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Hawley Inc.</b>				ADDRESS <b>1756 PA. AVE., N.W. DC</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 13 1958</b>	
				24b. REGISTRAR'S SIGNATURE <b>Over</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





6719

## CERTIFICATE OF DEATH

Reg. Dist. No. 06001

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro X</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) <b>Carol Ann</b>		First Middle Last <b>Coates</b>		4. DATE OF DEATH Month <b>May</b> Day <b>4</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 13, 57</b>	9. AGE (In years last birthday) <b>6 mo yrs.</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>21</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William Hager</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Lewis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Maggie Lewis Coates Upper Marlboro</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerosis left lung (cong)</b> <b>762.0</b> DUE TO <b>+ RLL + RML Rk lung.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>suppurated bronch secretion</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
INTERVAL BETWEEN ONSET AND DEATH					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>8:10A</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Dr Modlin</b>		ADDRESS (Street, city or town, state) <b>388 Montross Ave Landover Md</b>		DATE SIGNED <b>May 7 '58</b>	
PHYSICIAN'S NAME (Type) <b>Dr Modlin</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-7-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes</b>	
22d. LOCATION (City, town, or county) <b>Forrestville Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Myrtle K. Rollins</b>		ADDRESS <b>4339 Hunt Pl, NE</b>		24a. REC'D BY REGISTRAR <b>May 7 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Search</b>					

77

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2079389XV6

Myrtle K. Bell  
2194 Hunt Pl. N.E.  
Atlanta 2-7-28 St. Huber

Forrestal Mr.

## 5998 CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

COUNTY Prince George MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town.)  
 OR TOWN Hyattsville Md. LENGTH OF STAY (in this place) 6 mos.  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Carroll Manor Catholic Home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Pr. Geo's  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN Marlboro Maryland  
 STREET ADDRESS (If rural give location) Main Street

## 3. NAME OF DECEASED:

(First) Agatha (Middle) Wells (Last) Coffren  
 (Type or Print)

4. DATE OF DEATH: (Month) May (Day) 24 (Year) 1958

## 5. SEX:

Female

## 6. COLOR OR RACE:

White

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Widowed

## 8. DATE OF BIRTH:

July 4, 1870

9. AGE last birthday: 87 yrs. 10 UNDER 1 YEAR 15 UNDER 24 HRS.

## 10a. USUAL OCCUPATION Give kind of work done during most of working life,

Housewife

## 10b. KIND OF BUSINESS OR INDUSTRY:

Own Home

## 11. BIRTHPLACE (State or foreign country):

Maryland

## 12. CITIZEN OF WHAT COUNTRY?

U. S. A.

## 13. FATHER'S NAME:

Joseph Wells

## 14. MOTHER'S MAIDEN NAME:

Willie Ann Day

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY No.:

---

## 17. INFORMANT &amp; ADDRESS:

Mrs. Roland Ryon- Upper Marlboro, Md.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Metastatic Carcinoma of Brain

Interval Between Onset And Death

6 mos.

## Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

Carcinoma of Parotid gland

7 yrs

(c)

Wernic Coma (contributory)

30 days

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)  
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1957, to May 1958, that I last saw the deceased

alive on May 22, 1958, and that death occurred at 8:45 AM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

May 24-58

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

MAY 28 '58

Arthur

Ritchie Bros. Upper Marlboro, Md.

M

Agatha Coffren

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Un 4-2333

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06003

6983

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9720 Riggs Rd.				d. STREET ADDRESS 9720 Riggs Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Flora E. <del>Knox</del> Coyle				4. DATE OF DEATH Month May 23 Day Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1884 April 7, 1884	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Shelby, N. Car.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Floyd Ellis				14. MOTHER'S MAIDEN NAME Nannie Hopper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Guy P. Meredith, 9720 Riggs Rd. Adelphi, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.0 Acute exacerbation of Chronic Lymphatic leukemia DUE TO (b) leukemia DUE TO (c) Chronic Lymphatic leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 3 days 8 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5-1 1957, to 5-23 1958, that I last saw the deceased alive on 5-22 1958, and that death occurred at 5:10 a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE R.D. BAUER, M.D.				ADDRESS (Street, city or town, state) 2513 Buck Lodge Rd.		DATE SIGNED 5-23-58	
PHYSICIAN'S NAME (Type) R.D. BAUER, M.D.				DECEASED'S NAME (Type) Adelphi		DATE 5-23-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/26/58		22c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Mem. Cemetery		22d. LOCATION (City, town, or county) (State) Prince George County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE MAY 27 1958	
24b. REGISTRAR'S SIGNATURE							



CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10/15/1910"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS [Faint text, possibly "Married"]		DATE OF DEATH [Faint text, possibly "11/1/1955"]	
TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CERTIFICATE NO. [Faint text, possibly "12345"]		COUNTY [Faint text, possibly "Baltimore"]	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof to be furnished to the family of the deceased. It is to be retained for a period of ten years.

REGISTERED  
 [Faint text]

BALTIMORE, MARYLAND  
 [Faint text]

6920

## CERTIFICATE OF DEATH

06004

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>X Colmar Manor,</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS <b>3804 Newark Rd.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Julian T. Croson</b>		First Middle Last		4. DATE OF DEATH <b>MAY 23 1958</b>		Month Day Year		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 23- 1905</b>		9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Engr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lucerne Dairy</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles B. Croson</b>		14. MOTHER'S MAIDEN NAME <b>Ida Jane McDonald</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Dorothy L. Croson</b>		Address <b>3804 Newark Rd., Colmar Manor, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of dissecting aneurysm</b> <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>1/2</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 24, 1958</b> , to <b>May 23, 1958</b> , that I last saw the deceased alive on <b>May 20, 1958</b> , and that death occurred at <b>6:15 PM</b> , from the causes and on the date stated above.														ADDRESS (Street, city or town, state) <b>3132-16 1/2 St. NW. WASHINGTON DC.</b>		DATE SIGNED <b>1</b>					
ACTUAL SIGNATURE <b>Robert T. Kelley</b>				PHYSICIAN'S NAME (Type) <b>Robert T. KELLEY</b>				22a. BURIAL, CREMATION, or other (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 27-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Waxpool. Va.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros. 1661 Rd SE</b>				ADDRESS <b>Good Hope</b>				24a. REC'D BY REGISTRAR <b>DATE MAY 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED                  JAMES J. O'NEILL</p>		<p>AGE                  45</p>		<p>SEX                  Male</p>		<p>RACE                  White</p>	
<p>DATE OF DEATH                  May 10, 1907</p>		<p>TIME OF DEATH                  10:30 A.M.</p>		<p>PLACE OF DEATH                  Home</p>		<p>CITY                  Boston</p>	
<p>CAUSE OF DEATH                  Myocardial Infarction</p>		<p>IMMEDIATE CAUSE                  Coronary Thrombosis</p>		<p>PREVAILING DISEASE                  Hypertension</p>		<p>PREVAILING SYMPTOMS                  Headache, dizziness</p>	
<p>DATE OF BIRTH                  Nov. 15, 1861</p>		<p>PLACE OF BIRTH                  Ireland</p>		<p>EDUCATION                  Common School</p>		<p>OCCUPATION                  Laborer</p>	
<p>NAME OF PHYSICIAN                  Dr. J. H. O'Connell</p>		<p>NAME OF SURGEON                  Dr. J. H. O'Connell</p>		<p>NAME OF NURSE                  Mrs. J. H. O'Connell</p>		<p>NAME OF ATTENDING CLERGYMAN                  Rev. J. H. O'Connell</p>	
<p>SIGNATURE OF PHYSICIAN                  J. H. O'Connell</p>		<p>SIGNATURE OF SURGEON                  J. H. O'Connell</p>		<p>SIGNATURE OF NURSE                  Mrs. J. H. O'Connell</p>		<p>SIGNATURE OF ATTENDING CLERGYMAN                  Rev. J. H. O'Connell</p>	

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06005

6921

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Choverly		c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hosp			d. STREET ADDRESS 1510 - 59th Avenue		
3. NAME OF DECEASED (Type or print) Beulah Lee Cusick			4. DATE OF DEATH May 29 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 8, 1893		9. AGE (in years last birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John Horton			14. MOTHER'S MAIDEN NAME Jennie Southard		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Benjamin Lee Cusick, Hillside Spring	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 9020 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of left hip 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was standing on a chair and fell to floor			
20c. TIME OF INJURY Month, Day, Year 4:00 p.m. May 16 1958	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Hillside	(County) P.G.	(State) Md
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED May 29, 1958	
EXAMINER'S NAME (Type) JAMES I. BOYD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/2/58	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM.		22d. LOCATION (City, town, or county) BLADENSBURG, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Inc. Washington, D.C.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 4 '58	24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6222

CERTIFICATE OF DEATH

Reg. Dist. No.

06906

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write <b>Cheverly</b> RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>16 Mt. Rainier,</b> d. STREET ADDRESS <b>4100 32nd Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Boy Day</b>				4. DATE OF DEATH Month Day Year <b>May 12- 19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 12, 58</b>	
9. AGE (In years last birthday) yrs. Months Days Hours Min. <b>11 5</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Gerard Day</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Michel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral</b> <b>76.2.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 12, 19 58</b> to <b>May 12, 19 58</b> , that I last saw the deceased alive on <b>May 12, 19 58</b> , and that death occurred at <b>11:40 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>5302 Hamilton St, Hyattsville, Md 5/13/58</b>							
ACTUAL SIGNATURE <b>John W. Rubin</b>		PHYSICIAN'S NAME (Type) <b>John W. Rubin</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>5/19/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b>		ADDRESS <b>Administrator.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 22 58</b>		24b. REGISTRAR'S SIGNATURE <b>Allen Smith</b>	

2097202XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



22-23

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6084

CERTIFICATE OF DEATH

06007

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>				c. LENGTH OF STAY IN 1b <u>1 year</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5808 Ritchie Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wardie A LeANDAS Daye</u>				4. DATE OF DEATH Month Day Year <u>5-22-1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-12-1892</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Underground man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>P.E.P. Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>Forestville, md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Daye</u>				14. MOTHER'S MAIDEN NAME <u>Leanna B Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-09-3961</u>			
17. INFORMANT <u>BERTHA KASULKE</u>				Address <u>5810-Ritchie Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>MAY 22, 1958</u> , to <u>1</u> , 19____, that I last saw the deceased alive on <u>MAY 22</u> , 19 <u>58</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bruno Kocera</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>7200 MARLBORO PIKE SE. 5/22/58</u>			
PHYSICIAN'S NAME (Type) <u>BRUNO KOCEKA</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 26-58</u>		<u>Washington National</u>		<u>Southland md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Summers Bros 1661-gd Hope Rd Wash DC</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>	

CERTIFICATE OF DEATH

6024

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		JAN 5 1928		MOBILE, ALABAMA	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
MARRIED		JAN 15 1950		MEMPHIS, TENNESSEE	
OCCUPATION		DATE OF DEATH		PLACE OF DEATH	
CONGRESSMAN		APR 4 1968		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
HEART DISEASE		NATURAL		6024	
TIME OF DEATH		HOURS		MINUTES	
12:00 PM		12		00	
DATE OF REPORT		REPORTED BY		TITLE	
APR 5 1968		JAMES EARL RAY		DECEASED	
SIGNATURE OF REPORTER		SIGNATURE OF WITNESS		DATE	
JAMES EARL RAY		JAMES EARL RAY		APR 5 1968	

6024 JAY 068 011011  
 21011011011 011011 011011

APR 5 1968  
 12:00 PM  
 12 00  
 APR 5 1968  
 12:00 PM  
 12 00  
 APR 5 1968  
 12:00 PM  
 12 00

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 6023 CERTIFICATE OF DEATH

06008

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Prince George</i>		STATE <i>Md</i>		COUNTY <i>Prince George</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>		LENGTH OF STAY (in this place) <i>6 1/2 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>2008 Windham Road</i>				STREET ADDRESS (If rural give location) <i>2008 Windham Road</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Kathryn Elizabeth De Angelis</i>				<b>4. DATE OF DEATH</b> (Month) <i>May</i> (Day) <i>3</i> (Year) <i>1958</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>March 8 1883</i>	9. AGE last birthday <i>75</i> Yrs.	IF UNDER 1 YEAR Months <i></i> Days <i></i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>N.Y.C. New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Philip Doyle</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Patterson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>42-10-3983</i>		17. INFORMANT & ADDRESS <i>Mr Marguerite Muller Laurel Md 2008 Windham</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A) <i>Myocardial Infarction</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Severe Degenerative Heart Disease</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>and Coronary Sclerosis and generalized Atherosclerosis.</i>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <i>No operation</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) <i>No Injury</i>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <i>No Injury</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <i></i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>No Injury</i>			
22. I hereby certify that I attended the deceased from <i>May 3</i> 19 <i>58</i> to <i>May 3</i> 19 <i>58</i> , that I last saw the deceased alive on <i>May 3</i> 19 <i>58</i> , and that death occurred at <i>5:15 AM</i> from the causes and on the date stated above.							
SIGNATURE <i>Kathryn E. De Angelis</i>		ADDRESS (Street, city, town, state) <i>Laurel, Maryland</i>		DATE SIGNED <i>May 3, 1958</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>May 5 1958</i>		NAME OF CEMETERY OR CREMATORY <i>St Marys Cemetery</i>		LOCATION (City, town, or county) (State) <i>Laurel, Md.</i>	
24. REC'D BY REGISTRAR <i></i>		REGISTRAR'S SIGNATURE <i></i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Robert R. Norrell</i>		ADDRESS <i>Laurel Md</i>	
DATE <i>MAY 7 '58</i>							





## 6024 CERTIFICATE OF DEATH

Reg. Dist. No.

06009

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN 1b <b>25</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eugene Leland Memorial Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>5811 Quintana St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles E. Dougherty</b>				4. DATE OF DEATH Month Day Year <b>May 17 1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-11-72</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>Mary ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>?</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Hospital records</b> Address <b>Riverdale, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>8 1/2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County)		
					(State)		
21. I certify that I attended the deceased from <b>5-10</b> , 19 <b>58</b> to <b>5-17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5-17</b> , 19 <b>58</b> , and that death occurred at <b>11:00</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>D. P. Purdie</b> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 19, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>				24a. REC'D BY REGISTRAR <b>MAY 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06010

6025

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. LENGTH OF STAY IN lb <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aguasco</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hosp.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Walter Lee Douglas</u>				4. DATE OF DEATH <u>May 6 1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17, 1941</u>	
9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Lee Douglas</u>				14. MOTHER'S MAIDEN NAME <u>Marie Elizabeth Savoy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Edward Lee Douglas, Father #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 913.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Lobar pneumonia</u> (c) <u>stoking the underlying cause lost.</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>190x Several left tendon of Achilles</u></p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>stepped on an ax</u>					
20c. TIME OF INJURY <u>5:30 a.m. April 29, 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Aguasco P.D. Md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 6, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-10-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley Cem.</u>		22d. LOCATION (City, town, or county) <u>Aguasco Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. S. Nelson</u>				24a. REC'D BY REGISTRAR <u>DATE 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Dee Beach</u>	

DATE OF DEATH  
PLACE HERE

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THE EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS

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Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>12 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>D.</b> Last <b>Dunn</b>		4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-21-80</b>
9. AGE (In years last birthday) yrs. <b>78</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Garment Industry</b>		11. BIRTHPLACE (State or foreign country) <b>R. I.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John F. Dunn</b>		14. MOTHER'S MAIDEN NAME <b>Mary O'Donnel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Barbara Claridge Deal Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia Rt.</b> 1913 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BP in late hypertensive</b> DUE TO (c) <b>Coronary arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 May</b> , 19 <b>58</b> , to <b>31 May</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>31 May</b> , 19 <b>58</b> , and that death occurred at <b>8:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Upper Marlboro, Md</b> DATE SIGNED <b>1 June 58</b>			
ACTUAL SIGNATURE <b>R. B. Sasser</b> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 4-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deal Funeral Home</b>		24a. REC'D BY REGISTRAR <b>JUN 11 '58</b>	
ADDRESS <b>4812 Ga. Ave. N.W.</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JAN 11 1911  
JAN 11 1911

AMERICAN  
BOND

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
6728 CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		Caucasian		Roman Catholic		Single		Laborer		Heart Disease		Jan 10 1911		City of Baltimore		John Doe, M.D.		John Doe, Registrar	
Place of Birth		Date of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Dissection	
New York City		Jan 1 1866		Jan 5 1911		Jan 8 1911		Jan 10 1911		Jan 12 1911		Jan 15 1911		Jan 18 1911		Jan 21 1911		Jan 24 1911		Jan 27 1911		Jan 30 1911		Feb 2 1911	
Place of Residence		Date of Residence		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Dissection	
123 Main St, Baltimore		Jan 1 1866		Jan 5 1911		Jan 8 1911		Jan 10 1911		Jan 12 1911		Jan 15 1911		Jan 18 1911		Jan 21 1911		Jan 24 1911		Jan 27 1911		Jan 30 1911		Feb 2 1911	
Cause of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Dissection		Date of Dissection		Date of Dissection		Date of Dissection	
Heart Disease		Jan 10 1911		Jan 12 1911		Jan 15 1911		Jan 18 1911		Jan 21 1911		Jan 24 1911		Jan 27 1911		Jan 30 1911		Feb 2 1911		Feb 5 1911		Feb 8 1911		Feb 11 1911	
Place of Death		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Dissection		Date of Dissection		Date of Dissection		Date of Dissection	
City of Baltimore		Jan 10 1911		Jan 12 1911		Jan 15 1911		Jan 18 1911		Jan 21 1911		Jan 24 1911		Jan 27 1911		Jan 30 1911		Feb 2 1911		Feb 5 1911		Feb 8 1911		Feb 11 1911	
Signature of Physician		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature	
John Doe, M.D.		Jan 10 1911		Jan 12 1911		Jan 15 1911		Jan 18 1911		Jan 21 1911		Jan 24 1911		Jan 27 1911		Jan 30 1911		Feb 2 1911		Feb 5 1911		Feb 8 1911		Feb 11 1911	
Signature of Registrar		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature	
John Doe, Registrar		Jan 10 1911		Jan 12 1911		Jan 15 1911		Jan 18 1911		Jan 21 1911		Jan 24 1911		Jan 27 1911		Jan 30 1911		Feb 2 1911		Feb 5 1911		Feb 8 1911		Feb 11 1911	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6785 CERTIFICATE OF DEATH

Reg. Dist. No.

06011

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs, Md.				c. LENGTH OF STAY IN TB 18- Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Camp Springs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1267 - Brinkley Road S.E.				d. STREET ADDRESS 1267 - Brinkley Road S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SARAH JANE FARRELL				4. DATE OF DEATH May 12th. 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 6- 1872	
9. AGE (In years last birthday) yrs. 86		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) England.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Bradley				14. MOTHER'S MAIDEN NAME Elizabeth ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Joseph W. Farrell ( Son ) Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular disease (c) arteriosclerosis, rheumatoid 8 Years INTERVAL BETWEEN ONSET AND DEATH 2 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 19 58 to April 28 19 58 that I last saw the deceased alive on April 28 19 58 and that death occurred at 9:05 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Clinton, Maryland. May 12-58 ACTUAL SIGNATURE Alfred R. Lapin M.D. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 14-58		22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Summers Bros.				ADDRESS 1661- Good Hope Road S.E. Washington, D.C.		24a. REC'D BY REGISTRAR DATE MAY 13 58	
				24b. REGISTRAR'S SIGNATURE W. J. Seabach			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "Maryland"]		DATE OF BIRTH [Faint text, possibly "1910"]		PLACE OF DEATH [Faint text, possibly "Baltimore"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "June 15, 1955"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF INTERMENT [Faint text, possibly "St. Mary's Cemetery"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	

FILED IN

6-15-55  
 12  
 [Handwritten initials and numbers]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06012

6727

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Choverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Comoddy Hills	
c. LENGTH OF STAY IN 1b 16 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 7320 D Street N.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Cheryl		4. DATE OF DEATH May 10 1958	
5. SEX Female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/13/58	
9. AGE (In years last birthday) 5 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hubert W. Falkner		14. MOTHER'S MAIDEN NAME Grace La Fernier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Hubert W. Falkner		Address Comoddy Hills Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0 DUE TO Toxemia, exhaustion (b) Extensive lacerations of body (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 3-25 1958 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Comoddy Hills Pg Md (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 10, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/13/58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) Arlington Va (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gascho sons Hyattsville Md		24a. REC'D BY REGISTRAR DATE MAY 14 '58	
		24b. REGISTRAR'S SIGNATURE	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BATHING 75  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Faint, mostly illegible text and markings on a medical certificate form, including fields for patient information, cause of death, and examiner details.]*

1. I, the undersigned, being a duly qualified Medical Examiner, do hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the person named above, and that the cause of death is as stated.

2. I further certify that the death of the person named above was caused by the disease or condition stated, and that the death was not caused by any other disease or condition.

3. I further certify that the death of the person named above was not caused by any other disease or condition.

4. I further certify that the death of the person named above was not caused by any other disease or condition.

5. I further certify that the death of the person named above was not caused by any other disease or condition.

6. I further certify that the death of the person named above was not caused by any other disease or condition.

7. I further certify that the death of the person named above was not caused by any other disease or condition.

8. I further certify that the death of the person named above was not caused by any other disease or condition.

9. I further certify that the death of the person named above was not caused by any other disease or condition.

10. I further certify that the death of the person named above was not caused by any other disease or condition.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6728

## CERTIFICATE OF DEATH

Reg. Dist. No.

06013

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>21 hrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville</b> d. STREET ADDRESS <b>7109 Hawthorne St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Boy Follin</b>				4. DATE OF DEATH Month Day Year <b>5-10-58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-9-58</b>	
9. AGE (In years last birthday) yrs. <b>0</b>		IF UNDER 1 YEAR Months Days <b>21 10</b>		IF UNDER 24 HRS. Yrs. <b>10</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Follin</b>				14. MOTHER'S MAIDEN NAME <b>Germaine La Sonnda</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Neonatal asphyxia</b> <b>761.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Premature birth</b> DUE TO (c) <b>Premature separation of placenta</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost saw the deceased alive on _____, 19____, and that death occurred at <b>5:45P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>5102 Annapolis Rd Bladensburg, Md. 5/10/58</b> ACTUAL SIGNATURE <b>Julius Kauffman</b> M.D. PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>May 11/58</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Md.</b> 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>F. Gasch's Sons Hyattsville Md.</b> 24a. REC'D BY REGISTRAR DATE <b>MAY 14 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077235XVO

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "10/15/1917"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF BIRTH [Faint text, possibly "New York"]	
OCCUPATION [Faint text, possibly "Teacher"]		EDUCATION [Faint text, possibly "High School"]		RELIGION [Faint text, possibly "Roman Catholic"]	
MARITAL STATUS [Faint text, possibly "Married"]		NUMBER OF CHILDREN [Faint text, possibly "3"]		DATE OF MARRIAGE [Faint text, possibly "1910"]	
NAME OF PHYSICIAN [Faint text, possibly "Dr. Smith"]		NAME OF FUNERAL HOME [Faint text, possibly "Doe & Sons"]		NAME OF BURIAL PLACE [Faint text, possibly "St. Mary's Cemetery"]	
NAME OF NEXT OF KIN [Faint text, possibly "Mrs. Jane Doe"]		ADDRESS OF NEXT OF KIN [Faint text, possibly "123 Main St, New York"]		NAME OF WITNESS [Faint text, possibly "John Doe"]	
NAME OF REGISTRAR [Faint text, possibly "John Doe"]		ADDRESS OF REGISTRAR [Faint text, possibly "123 Main St, New York"]		NAME OF CLERK [Faint text, possibly "John Doe"]	

BUREAU OF HEALTH  
 DEPARTMENT OF HEALTH  
 STATE OF NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6086 CERTIFICATE OF DEATH

Reg. Dist. No.

06014

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Hgts</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Hgts</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>15020-25th Place</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Agnes</u> Last <u>Gibson</u>		4. DATE OF DEATH <u>May 17</u> 19 <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-24-1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Bietzehl</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wesen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Louis Gibson</u>		Address <u>same as</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adeno Carcinoma</u> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Site undetermined</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 10, 1958</u> , to <u>May 17, 1958</u> , that I last saw the deceased alive on <u>May 15, 1958</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Timothy F. O'Donovan M.D.</u>		ADDRESS (Street, city or town, state) <u>2811a Ave SE</u> DATE SIGNED <u>5/17/58</u>	
PHYSICIAN'S NAME (Type) <u>TIMOTHY F. O'DONOVAN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5/20/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>	22d. LOCATION (City, town, or county) (State) <u>Bushwood Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Mattingly</u>		ADDRESS <u>131-11th St Wash. D.C.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arden</u>	
DATE <u>MAY 20 '58</u>			





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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6087 CERTIFICATE OF DEATH

06015

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10199 Riggs Road</b>				d. STREET ADDRESS <b>10199 Riggs Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>IRENE</b> <b>KELLNER</b> <b>GINSBERG</b>				4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 28, 1897</b>	
9. AGE (In years lost by day) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered Nurse</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Kaufman Kellner</b>				14. MOTHER'S MAIDEN NAME <b>Augusta Price</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Samuel B. Ginsberg - 10199 Riggs Rd., Adelphi, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of breast</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>24 mo.</b> <b>3 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>12-26</b> , 19 <b>58</b> , to <b>5-5</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5-4</b> , 19 <b>58</b> , and that death occurred at <b>7 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2513 Buckledge Rd. Adelphi Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>R.D. Bauer</b> M.D. <b>2513 Buckledge Rd. Adelphi Md.</b> PHYSICIAN'S NAME (Type) <b>R.D. BAUER, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>May 6, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Danzansky &amp; Sons-3501 14th St., N.W.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Albert Smith</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06016

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheney</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5030 Silver Hill Road</u>			d. STREET ADDRESS <u>5030 Silver Hill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Lillian</u> First <u>Gleason</u> Middle <u></u> Last <u></u>			4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 27, 1868</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Henry M. Norton</u>		
14. MOTHER'S MAIDEN NAME <u>Estelle Bunting</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		
16. SOCIAL SECURITY NO. <u>1</u>			17. INFORMANT <u>William D. Norton</u> Address <u>5030 Silver Hill Rd</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart</u> <u>9020</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>fracture of the left intertrochanteric</u> (c) <u></u> DUE TO cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u></u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Went to sit on a chair and fell to floor</u>			
20c. TIME OF INJURY Month, Day, Year <u>May 5-11 1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Silver Hill P.G. Md</u>	(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>May 21, 1958</u>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-24-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Adair Hill Cemetery</u>	22d. LOCATION (City, town, or county) <u>Shiloh Maryland</u>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamber to Inc. 517-11-11</u>			24a. REC'D BY REGISTRAR DATE <u>MAY 23 '58</u>		
			24b. REGISTRAR'S SIGNATURE <u>W. W. Chamber to Inc.</u>		

*[Faint, mostly illegible text and markings on a medical certificate form, including fields for patient information, cause of death, and examiner details.]*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6030

## CERTIFICATE OF DEATH

Reg. Dist. No.

10017

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>KATHERINE</b> Middle <b>GOBBETT</b> Last <b>GOBBETT</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>13</b> Year <b>1958</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>15 April 1896</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>ITALY</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Dominick Paulino</b>				14. MOTHER'S MAIDEN NAME <b>JOSEPHINE BRIENZA</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>-</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>190.8</b> IMMEDIATE CAUSE (a) <b>MALIGNANT MELANOMA WITH Generalized Metastasis</b> DUE TO (b) <b>2 1/2 yrs</b> DUE TO (c) <b>2 1/2 yrs</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>JULY</b> , 19 <b>56</b> , to <b>MAY 13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 13</b> , 19 <b>58</b> , and that death occurred at <b>12:25</b> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William D. Rosson M.D.</b>				ADDRESS (Street, city or town, state) <b>5304 Annapolis Road</b> DATE SIGNED <b>May 13 1958</b>			
PHYSICIAN'S NAME (Type) <b>William Rosson M.D.</b>				<b>Bladensburg, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>5/16/58</b>		<b>5/16/58</b>		<b>FORT LINCOLN</b>		<b>BLADENSBURG</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Lee Sons - Wash. D. C.</b>				24a. REC'D BY REGISTRAR <b>MAY 15 1958</b> 24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		1910		Boston	
Cause of Death		Disease		Symptoms		Duration		Time of Day		Month	
Heart Disease		Myocardial Infarction		Chest Pain		2 Weeks		10:00 AM		April	
Occupation		Education		Marital Status		Previous Illnesses		Manner of Death		Signature of Physician	
Teacher		High School		Married		None		Natural		[Signature]	
Residence		City		County		State		Burial Place		Signature of Registrar	
123 Main St		Boston		Suffolk		Mass		Cemetery		[Signature]	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 1910

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06918

6031

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>2 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		e. STREET ADDRESS <u>7746 Garrison Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>W</u> Last <u>Good</u>		4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 Apr. 1908</u>
9. AGE (In years, last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRANSIT</u>	
11. BIRTHPLACE (State or foreign country) <u>EDINBURGH VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN H GOOD</u>		14. MOTHER'S MAIDEN NAME <u>ALICE WEISMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-22-2140</u>	
17. INFORMANT <u>ANNIE GOOD</u>		Address <u>7746 GARRISON RD BALDWIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis Rb coronary artery</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1 Jan</u> , 19 <u>51</u> , to <u>26 MAY 19 58</u> , that I last saw the deceased alive on <u>26 MAY</u> , 19 <u>58</u> , and that death occurred at <u>3:15 A</u> .M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John H Kehoe</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>Dr. John Kehoe</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>May 27, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <u>Mt Jackson, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J M Lee &amp; Sons</u>		ADDRESS <u>300 4th St N.E.</u>	24a. REC'D BY REGISTRAR <u>May 28 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint text, possibly "John Doe"]</p>		<p>2. SEX                  [Faint text, possibly "Male"]</p>	
<p>3. AGE                  [Faint text, possibly "45 years"]</p>		<p>4. DATE OF DEATH                  [Faint text, possibly "Jan 15, 1912"]</p>	
<p>5. PLACE OF DEATH                  [Faint text, possibly "Home"]</p>		<p>6. CAUSE OF DEATH                  [Faint text, possibly "Heart failure"]</p>	
<p>7. OCCASION OF DEATH                  [Faint text, possibly "Natural causes"]</p>		<p>8. SIGNATURE OF PHYSICIAN                  [Faint signature]</p>	
<p>9. SIGNATURE OF WITNESS                  [Faint signature]</p>		<p>10. SIGNATURE OF DECEASED                  [Faint signature]</p>	
<p>11. SIGNATURE OF REGISTRAR                  [Faint signature]</p>		<p>12. SIGNATURE OF CLERK                  [Faint signature]</p>	

EX-111 BIO-MID

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6988 CERTIFICATE OF DEATH

Reg. Dist. No.

06019

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>				c. LENGTH OF STAY IN 1b <b>2 wks.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4325 Clagett Rd., University Park,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eleven Cedars Nursing Home</b>				d. STREET ADDRESS <b>4325 Clagett Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Hammet</b> Last <b>Gordon</b>				4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>19 58</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 31, 1867</b>	
9. AGE (In years last birthday) <b>90</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				13. FATHER'S NAME <b>Charles G Gordon</b>			
14. MOTHER'S MAIDEN NAME <b>Parthenia E. Mc Kelden</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			
16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT Address <b>Mrs. Virginia B. Hargett - University Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia secondary to suppurative parotitis, rt.</b> <b>537X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis, advanced</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April</b> , 19 <b>58</b> , to <b>May</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 11</b> , 19 <b>58</b> , and that death occurred at <b>2:20 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b>				ADDRESS (Street, city or town, state) <b>4713 Berwyn Rd.,</b>			
DATE SIGNED <b>5/12/58</b>				M.D. <b>Wolcott L. Etienne, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>College Park, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/14/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 19 58</b>	
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

66020

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville</b> d. STREET ADDRESS <b>6715 Queens Chapel Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frances Sabina Graves</b>		4. DATE OF DEATH Month Day Year <b>May 24 19 58</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 9 th, 1886</b>	
9. AGE (In years last birthday) <b>72 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired clerk</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Edw. Daiger</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Allen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-22-1140</b>	
17. INFORMANT <b>Willis B. Henderson; same address as # 2.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary atherosclerosis</b> DUE TO (c) <b>Cardiovascular renal disease</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Colmar Manor, Md.</b>		20g. (County) <b>Pr. Geo.</b>	
20h. (State) <b>Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>John T. Maloney</b> EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		DATE SIGNED <b>May 24, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 27, 1958</b>	
22c. NAME OF CEMETERY OR CREATION <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch &amp; Sons Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>May 26 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Overland</b>		24c. REGISTRAR'S SIGNATURE <b>Overland</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BIRMINGHAM 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John F. Taylor, Jr.	
Sex		Male	
Age		35	
Date of Birth		May 21, 1932	
Place of Birth		Birmingham, Alabama	
Usual Residence		Birmingham, Alabama	
Cause of Death		Coronary atherosclerosis	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Date		May 21, 1968	
Place		Birmingham, Alabama	
Signature of Coroner		[Signature]	
Date		May 21, 1968	
Place		Birmingham, Alabama	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C6021

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 to the funeral director. Page 5 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt Rainier</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>16 Mount Rainier</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3108 Varnum Street</b>			d. STREET ADDRESS <b>3108 Varnum Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Thomas</b> First <b>Green</b> Middle <b>Green</b> Last			4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>19 58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-23-1885</b>		9. AGE (In years last birthday) <b>73</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auditor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Accounting</b>		11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>George Steuart Green</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Wharton</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>yes WW#1</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Lillian Green ; same address as # 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>442X</b> IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO (b) <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>May 22, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/26/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.-Washington, D. C.</b>			24a. REC'D BY REGISTRAR <b>DATE MAY 26 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

Prison Service

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## 6033 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN TB <b>5 H 55 Min</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cedar Hgts.</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				f. STREET ADDRESS <b>900 64th Ave.,</b>			
3. NAME OF DECEASED (Type or print) First <b>Pearl</b> Middle <b>Griffin</b> Last				4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Approx. 65 yrs.</b>	
9. AGE (In years last birthday) <b>65</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>✓</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>✓</b>				14. MOTHER'S MAIDEN NAME <b>✓</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Pulmonary Edema</b> 443x DUE TO <b>Cerebral Vascular Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Hypertensive cardio-vascular disease</b> (b) <b>Hypertensive cardio-vascular disease</b> (c) <b>Hypertensive cardio-vascular disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 5-2-58</b> 19, to <b>May 19</b> 19, that I last saw the deceased alive on <b>5-2-58</b> 19, and that death occurred at <b>9:25 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W.C. Etienne</b> M.D.				ADDRESS (Street, city or town, state) <b>4713 TERRY RD S.W.</b>			
PHYSICIAN'S NAME (Type) <b>W.C. ETIENNE</b>				DATE SIGNED <b>5/4/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>5/9/58</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>				22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.H. Bacon</b>				ADDRESS <b>1722 7th St. N.W. Wash D.C.</b>			
24a. REC'D BY REGISTRAR <b>DATE MAY 12 '58</b>				24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06023

FOR STATE  
HEALTH DEPT.

Items 13 & 14, Film G229, 5/20/58 fcy

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Piscataway</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Piscataway</u>	
c. LENGTH OF STAY IN 1b <u>5 years</u>		d. STREET ADDRESS <u>Lorington Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lorington Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alice</u> First <u>Florence</u> Middle <u>Groves</u> Last		4. DATE OF DEATH <u>May</u> 13 1958	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct</u> 1914
9. AGE (in years last birthday) <u>43</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Milton Blake Groves, same as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular revascular disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 13, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/15/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>MARTIN W. HYSOING COMPANY INC. 1300 N. STREET, N. W.</u>		24a. REC'D BY REGISTRAR <u>May 15 1958</u>	
		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various checkboxes.]*

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

## 6090 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Langley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47x.3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Har-a-Rest Home</u>		d. STREET ADDRESS <u>4509 Ill Ave. NW</u>	
3. NAME OF DECEASED (Type or print) <u>MARY VIRGINIA HAMMERLY</u>		4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 5, 1867</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H. W.</u>	
11. BIRTHPLACE (State or foreign country) <u>Wheatland Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Beans</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Alder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John E Hammerly</u>		Address <u>3805 39th St NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>over 2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>56</u> , to <u>May 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 2</u> , 19 <u>58</u> , and that death occurred at <u>5 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis H Shuman</u>		ADDRESS (Street, city or town, state) <u>1635 Mass. Ave. N.W.</u>	
PHYSICIAN'S NAME (Type) <u>Louis H. Shuman, M.D.</u>		LOCATION (City, town, or county) (State) <u>Washington 6 DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 6, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Armed Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Hillboro Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u>		ADDRESS <u>4812 Ga. Ave. NW</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE

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RESIDENT OF

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6934

CERTIFICATE OF DEATH

06025

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md</b> c. LENGTH OF STAY IN 1b <b>2 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>38 Chevery Md</b> d. STREET ADDRESS <b>3807 58th Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>D</b> Last <b>Henderson</b>		4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/24/13</b>
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Planner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U S Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>	
13. FATHER'S NAME <b>Gilbert G Henderson</b>		14. MOTHER'S MAIDEN NAME <b>Lottie M Hancock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>WW 11</b>	
17. INFORMANT <b>Lillina E. Henderson</b>		Address <b>Cheverly Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 420.0 DUE TO <b>Thrombotic occlusion in left coronary artery</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arterio-sclerotic heart disease</b> (b) <b>2 days</b> (c) <b>2 days</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 mo.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 13 19 58</b> to <b>May 7, 19 58</b> , that I last saw the deceased alive on <b>May 7, 19 58</b> , and that death occurred at <b>8:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5304 Annapolis Rd, Bladensburg, Md</b> DATE SIGNED ACTUAL SIGNATURE <b>William D. Rossen M.D.</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 10, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24a. REC'D BY REGISTRAR <b>Hyattsville Maryland.</b>	
24b. REGISTRAR'S SIGNATURE <b>May 13 58</b>			

CERTIFICATE OF DEATH

BONN

March 14-18

2nd floor front

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66026

Reg. Dist. No.

6935

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Indiana</b> b. COUNTY <b>Indianapolis</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indianapolis</b> 52 x .3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			d. STREET ADDRESS <b>3463 East 36th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>Coulter</b> Last <b>Henrickson</b>			4. DATE OF DEATH Month <b>May</b> Day <b>6th</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 4, 1876</b>		9. AGE (In years last birthday) <b>81</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Henry Scholl</b>			14. MOTHER'S MAIDEN NAME <b>F.ances Bell</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>James Coulter, thru Hines Funeral Home.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b>  <b>442x</b> DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease</b>            DUE TO (c)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>May 6, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>5/6/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bunnell Cemetery</b>	
		ADDRESS <b>The S. H. Hines Co.-2901 14th St. N.W.</b>		22d. LOCATION (City, town, or county) (State) <b>Frankfort, Indiana</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 7 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Alfred</i>	

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHING 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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Prince George

Georgetown

A.A.

Indiana

John James Smith

Prince George

6th

May

Hammond

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STATE OF  
WEST VIRGINIA  
COUNTY OF

June 1, 1910

John James Smith

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John James Smith

Cardiovascular renal disease

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May 6, 1910

John T. Smith, M.D.

Hammond, Indiana

Hammond, Indiana

Hammond, Indiana

John T. Smith, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6091 CERTIFICATE OF DEATH

06027

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 1 yr. 6 mos. and 20 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 2122 Mass., Avenue, N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JEREMIAH HENRY		4. DATE OF DEATH Month Day Year May 27, 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31/1905
9. AGE (In years last birthday) 53 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Servant		10b. KIND OF BUSINESS OR INDUSTRY Lodge Hotel	
11. BIRTHPLACE (State or foreign country) French West Indies		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Joshua James		14. MOTHER'S MAIDEN NAME Ida Bertha Henry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No -		16. SOCIAL SECURITY NO. 578-38-3242	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary tuberculosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 6 yrs.,	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sarcoidosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. s. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 7, 1956, to May 27, 1958, that I last saw the deceased alive on May 26, 1958, and that death occurred at 12:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital 5/27/58 ACTUAL SIGNATURE Moe Weiss M.D. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 6-4-58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Woburn		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Ph... 901-3075W.		24a. REC'D BY REGISTRAR DATE JUN 3 '58	
24b. REGISTRAR'S SIGNATURE W. Beach			



## MARYLAND STATE DEPARTMENT OF REALTY-BALTIMORE 12

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6092

## CERTIFICATE OF DEATH

Reg. Dist. No.

06928

1. PLACE OF DEATH o. COUNTY <u>PR. GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MICHIGAN PR. HILLS</u>				c. LENGTH OF STAY IN 1b <u>5 MOS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>5402-14<sup>TH</sup> PL.</u>				d. STREET ADDRESS <u>1 5402-14<sup>TH</sup> PL.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>PAULINE</u> Last <u>HIGGS</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 25 1879</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ALFRED HIGGS</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE WELSH</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. KATHERINE HUNTER</u>		Address <u>5402-14<sup>TH</sup> PL.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 6, 1958</u> to <u>May 8, 1958</u> , that I last saw the deceased alive on <u>May 8, 1958</u> , and that death occurred at <u>1:00 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Willard Camahier, Jr.</u>				ADDRESS (Street, city or town, state) <u>1801-8<sup>TH</sup> ST. N.W.</u>		DATE SIGNED <u>5/9/58</u>	
PHYSICIAN'S NAME (Type) <u>C. WILLARD CAMAHIER, JR.</u>				<u>Wash, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-12-58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>CHRIST CHURCH CEMETARY</u>		22d. LOCATION (City, town, or county) (State) <u>CHAPILLO</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.</u>				ADDRESS <u>RIVERDALE MD</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 12 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 6036 CERTIFICATE OF DEATH

Reg. Dist. No.

06029

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel General Hospital, Inc.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural - Laurel</u>			
				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Hill</u> Last <u>Hill</u>				4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 10, 1887</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Columbus Brashears</u>				14. MOTHER'S MAIDEN NAME <u>Susan Fletcher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Burns Hill</u> Address <u>Laurel Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> <u>199.2</u> DUE TO <u>generalized carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>5/22, 1958</u> , that I last saw the deceased alive on <u>5/21, 1958</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>  </u>							
ACTUAL SIGNATURE <u>B. P. Warren</u>							
PHYSICIAN'S NAME (Type) <u>B. P. Warren, M. D., 305 Prince George St., Laurel, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 24, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>My Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwitt Canaldson, Laurel, Md</u>				24. REC'D BY REGISTRAR DATE <u>JUN 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6093 CERTIFICATE OF DEATH

Reg. Dist. No.

06030

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLSIDE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6234 MARLBORO PIKE</u>				d. STREET ADDRESS <u>6234 Marlboro Pike</u>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>E</u> Last <u>HOILE</u>				4. DATE OF DEATH Month <u>5</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 13 1894</u>	
9. AGE (In years last birthday) yrs. <u>63</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>HENRY HOILE</u>				14. MOTHER'S MAIDEN NAME <u>ISABELLE DAWSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-48-2333</u>			
17. INFORMANT <u>SHERIDAN HOILE</u>				Address <u>6234 Marlboro Pike Hillside Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Kidney with metastases.</u> <u>180x</u> DUE TO <u>(clear Cell CA of Kidney)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Dec 1959</u> <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>March, 1958</u> , to <u>May, 1958</u> , that I last saw the deceased alive on <u>5/18, 1958</u> , and that death occurred at <u>8:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John T. Lynn</u>				M.D. <u>5241 St. Barnabas Rd SE</u>			
PHYSICIAN'S NAME (Type) <u>John T. Lynn MD.</u>				DATE SIGNED <u>5/21/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5-24-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL</u>	
22d. LOCATION (City, town, or county) <u>Washington, D.C.</u>				22e. (State) <u>D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Inc</u>				ADDRESS <u>Washington DC</u>		24a. REC'D BY REGISTRAR <u>  </u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>				DATE <u>  </u>			



## 6037 CERTIFICATE OF DEATH

06031

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colmar Manor</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>4327 Lawrence Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Esther</b> Middle <b>C.</b> Last <b>Holmes</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/4/07</b>
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Williamsport, Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John Zwisle</b>		14. MOTHER'S MAIDEN NAME <b>Annie Croucher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>042-10-4621</b>	
17. INFORMANT <b>George M. Holmes</b>		Address <b>4327 Lawrence Street, Colmar Manor, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate case (a), stating the underlying cause lost. (b) <b>Coronary Heart Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 27, 1957</b> , to <b>May 10, 1958</b> , that I last saw the deceased alive on <b>May 2, 1958</b> , and that death occurred at <b>4:35 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas J. Kelly</b>		ADDRESS (Street, city or town, state) <b>6480 N. H. Ave., Takoma Park, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Thomas J. Kelly</b>		DATE SIGNED <b>5/10/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/14/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wildwood</b>	22d. LOCATION (City, town, or county) (State) <b>Williamsport, Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Willard E. Vincent</b>		24a. REC'D BY REGISTRAR <b>MAY 12 '58</b>	
ADDRESS <b>2525 Bladensburg Rd., N. E., Washington 18, D. C.</b>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <b>John E. Egan</b></p>		<p>2. Sex: <b>Male</b></p>	
<p>3. Date of birth: <b>May 20, 1907</b></p>		<p>4. Age: <b>21 years</b></p>	
<p>5. Place of birth: <b>Baltimore, Md.</b></p>		<p>6. Date of death: <b>May 20, 1928</b></p>	
<p>7. Cause of death: <b>Cholera</b></p>		<p>8. Duration of illness: <b>1 day</b></p>	
<p>9. Name of physician: <b>Dr. J. E. Egan</b></p>		<p>10. Name of funeral home: <b>John E. Egan</b></p>	
<p>11. Name of next of kin: <b>John E. Egan</b></p>		<p>12. Name of informant: <b>John E. Egan</b></p>	
<p>13. Name of hospital: <b>John E. Egan</b></p>		<p>14. Name of cemetery: <b>John E. Egan</b></p>	
<p>15. Name of registrar: <b>John E. Egan</b></p>		<p>16. Name of registrar: <b>John E. Egan</b></p>	
<p>17. Name of registrar: <b>John E. Egan</b></p>		<p>18. Name of registrar: <b>John E. Egan</b></p>	
<p>19. Name of registrar: <b>John E. Egan</b></p>		<p>20. Name of registrar: <b>John E. Egan</b></p>	
<p>21. Name of registrar: <b>John E. Egan</b></p>		<p>22. Name of registrar: <b>John E. Egan</b></p>	
<p>23. Name of registrar: <b>John E. Egan</b></p>		<p>24. Name of registrar: <b>John E. Egan</b></p>	
<p>25. Name of registrar: <b>John E. Egan</b></p>		<p>26. Name of registrar: <b>John E. Egan</b></p>	
<p>27. Name of registrar: <b>John E. Egan</b></p>		<p>28. Name of registrar: <b>John E. Egan</b></p>	
<p>29. Name of registrar: <b>John E. Egan</b></p>		<p>30. Name of registrar: <b>John E. Egan</b></p>	
<p>31. Name of registrar: <b>John E. Egan</b></p>		<p>32. Name of registrar: <b>John E. Egan</b></p>	
<p>33. Name of registrar: <b>John E. Egan</b></p>		<p>34. Name of registrar: <b>John E. Egan</b></p>	
<p>35. Name of registrar: <b>John E. Egan</b></p>		<p>36. Name of registrar: <b>John E. Egan</b></p>	
<p>37. Name of registrar: <b>John E. Egan</b></p>		<p>38. Name of registrar: <b>John E. Egan</b></p>	
<p>39. Name of registrar: <b>John E. Egan</b></p>		<p>40. Name of registrar: <b>John E. Egan</b></p>	
<p>41. Name of registrar: <b>John E. Egan</b></p>		<p>42. Name of registrar: <b>John E. Egan</b></p>	
<p>43. Name of registrar: <b>John E. Egan</b></p>		<p>44. Name of registrar: <b>John E. Egan</b></p>	
<p>45. Name of registrar: <b>John E. Egan</b></p>		<p>46. Name of registrar: <b>John E. Egan</b></p>	
<p>47. Name of registrar: <b>John E. Egan</b></p>		<p>48. Name of registrar: <b>John E. Egan</b></p>	
<p>49. Name of registrar: <b>John E. Egan</b></p>		<p>50. Name of registrar: <b>John E. Egan</b></p>	
<p>51. Name of registrar: <b>John E. Egan</b></p>		<p>52. Name of registrar: <b>John E. Egan</b></p>	
<p>53. Name of registrar: <b>John E. Egan</b></p>		<p>54. Name of registrar: <b>John E. Egan</b></p>	
<p>55. Name of registrar: <b>John E. Egan</b></p>		<p>56. Name of registrar: <b>John E. Egan</b></p>	
<p>57. Name of registrar: <b>John E. Egan</b></p>		<p>58. Name of registrar: <b>John E. Egan</b></p>	
<p>59. Name of registrar: <b>John E. Egan</b></p>		<p>60. Name of registrar: <b>John E. Egan</b></p>	
<p>61. Name of registrar: <b>John E. Egan</b></p>		<p>62. Name of registrar: <b>John E. Egan</b></p>	
<p>63. Name of registrar: <b>John E. Egan</b></p>		<p>64. Name of registrar: <b>John E. Egan</b></p>	
<p>65. Name of registrar: <b>John E. Egan</b></p>		<p>66. Name of registrar: <b>John E. Egan</b></p>	
<p>67. Name of registrar: <b>John E. Egan</b></p>		<p>68. Name of registrar: <b>John E. Egan</b></p>	
<p>69. Name of registrar: <b>John E. Egan</b></p>		<p>70. Name of registrar: <b>John E. Egan</b></p>	
<p>71. Name of registrar: <b>John E. Egan</b></p>		<p>72. Name of registrar: <b>John E. Egan</b></p>	
<p>73. Name of registrar: <b>John E. Egan</b></p>		<p>74. Name of registrar: <b>John E. Egan</b></p>	
<p>75. Name of registrar: <b>John E. Egan</b></p>		<p>76. Name of registrar: <b>John E. Egan</b></p>	
<p>77. Name of registrar: <b>John E. Egan</b></p>		<p>78. Name of registrar: <b>John E. Egan</b></p>	
<p>79. Name of registrar: <b>John E. Egan</b></p>		<p>80. Name of registrar: <b>John E. Egan</b></p>	
<p>81. Name of registrar: <b>John E. Egan</b></p>		<p>82. Name of registrar: <b>John E. Egan</b></p>	
<p>83. Name of registrar: <b>John E. Egan</b></p>		<p>84. Name of registrar: <b>John E. Egan</b></p>	
<p>85. Name of registrar: <b>John E. Egan</b></p>		<p>86. Name of registrar: <b>John E. Egan</b></p>	
<p>87. Name of registrar: <b>John E. Egan</b></p>		<p>88. Name of registrar: <b>John E. Egan</b></p>	
<p>89. Name of registrar: <b>John E. Egan</b></p>		<p>90. Name of registrar: <b>John E. Egan</b></p>	
<p>91. Name of registrar: <b>John E. Egan</b></p>		<p>92. Name of registrar: <b>John E. Egan</b></p>	
<p>93. Name of registrar: <b>John E. Egan</b></p>		<p>94. Name of registrar: <b>John E. Egan</b></p>	
<p>95. Name of registrar: <b>John E. Egan</b></p>		<p>96. Name of registrar: <b>John E. Egan</b></p>	
<p>97. Name of registrar: <b>John E. Egan</b></p>		<p>98. Name of registrar: <b>John E. Egan</b></p>	
<p>99. Name of registrar: <b>John E. Egan</b></p>		<p>100. Name of registrar: <b>John E. Egan</b></p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6738

## CERTIFICATE OF DEATH

Reg. Dist. No. 66032

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>17 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville,</b> d. STREET ADDRESS <b>5626 Elberton Pl.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Homer Lee Hughes Jr</b>		4. DATE OF DEATH Month Day Year <b>May 27 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 June 1901</b>
9. AGE (In years last birthday) <b>56 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Monumental Life Ins. Co., Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Homer L. Hughes</b>		14. MOTHER'S MAIDEN NAME <b>Jane Gray</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. Anna Howard Hughes</b>		Address <b>Hyattsville, Md. 5626 Elberton Pl.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> 441X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malignant Hypertension</b> DUE TO (c) <b>Lobar pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>490X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 10, 19 58</b> to <b>May 27, 19 58</b> , that I last saw the deceased alive on <b>May 27, 19 58</b> , and that death occurred at <b>6 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5304 Annapolis Rd., Bladensburg, Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>William D. Rosson MD</b>		PHYSICIAN'S NAME (Type) <b>William D. Rosson</b>	
22a. BURIAL, CREMATION, REMOVAL, SPECIAL <b>burial</b>		22b. DATE THEREOF <b>5/30/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bethany Methodist Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co., 2901 14th St. N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 29 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5999

## CERTIFICATE OF DEATH

Item 1 Film 0228 5-15-58 et

Reg. Dist. No.

06033

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>15</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4819 Rockford Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HULDA</u> Middle <u>ELIZABETH</u> Last <u>HUNTER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 29 1896</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Government Justice Dept</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>District of Columbia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Broadwater Hunter</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH TINDLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs Lorena Granati</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Ovary</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Operation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I for Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1956</u> to <u>2/8/58</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>4/10/58</u> , 19 <u>  </u> , and that death occurred at <u>  </u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Ross Morris</u> M.D. <u>1801-Edge St. N.W. Wash. D.C.</u>		DATE SIGNED <u>  </u>	
PHYSICIAN'S NAME (Type) <u>W. Ross Morris</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 10th, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home --</u>		ADDRESS <u>Washington D.C.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6939

## CERTIFICATE OF DEATH

Reg. Dist. No.

66034

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md</b>				c. LENGTH OF STAY IN 1b <b>15</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Irwin</b> Last <b>Irwin</b>				4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-17-88</b>		9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min.	IF UNDER 24 HRS. Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shop Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Road Comm.</b>		11. BIRTHPLACE (State or foreign country) <b>Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Harry C Irwin</b>				14. MOTHER'S MAIDEN NAME <b>Ada M Ginter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W W 1</b>		17. INFORMANT <b>Margaret M Irwin</b> Address <b>Hyattsville Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia</b> DUE TO <b>162.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Primary Carcinoma Lung - Metastasis</b> DUE TO <b>7 months</b> (c) <b>7 months</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>11:22 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4124-41st Ave. Hyattsville, Md</b> DATE SIGNED <b>5/10/58</b>							
ACTUAL SIGNATURE <b>Gordon W. Kelley</b>				PHYSICIAN'S NAME (Type) <b>Dr. G. Kelley</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 13, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort L. ncoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 14 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Alfred</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

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NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6994

Reg. Dist. No.

07152

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2200 Block Lackawanna Street</b>			d. STREET ADDRESS <b>2200 Block Lackawanna Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Elmer Joseph Jenkins</b>			4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>19 58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-25-17</b>		9. AGE (In years last birthday) <b>40</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Jesse James Jenkins</b>		14. MOTHER'S MAIDEN NAME <b>Grace ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Roberta Jenkins; same address as # 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Universal 3rd and 4th degree burns of body.</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Burns due to conflagration in home</b>			
20c. TIME OF INJURY Month, Day, Year <b>12-15-58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Adelphi, Pr. Geo.</b>		20g. (County) (State) <b>MD.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 17, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/21/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GEORGE WASHINGTON CEMETERY</b>	
22d. LOCATION (City, town, or county) (State) <b>HYATTSVILLE, MD.</b>		24a. REC'D BY REGISTRAR <b>May 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Robert Smith</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey</b>		ADDRESS <b>SILVER SPRING, MD.</b>			

M

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MEDICAL CERTIFICATION

2

BT

450

50-25-54

Figure 1

540

02-1-2

John F. Kennedy

## 6240 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>4 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Lanham</b> d. STREET ADDRESS <b>Rt 1 Box 14 A</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Baby Boy Lawrence Jones</b>				4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 11, 1958</b>	
9. AGE (In years last birthday) yrs. <b>4</b>		IF UNDER 1 YEAR Months <b>4</b>		IF UNDER 24 HRS. Hours <b>4</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Lawrence F Jones</b>				14. MOTHER'S MAIDEN NAME <b>Shirley Jenkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital records Cheverly, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Paralysis</b> <b>751X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Meningo myeloid tumor area</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-11</b> , 19 <b>58</b> to <b>5-15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5-15</b> , 19 <b>58</b> , and that death occurred at <b>2:30</b> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George Hageage</b>				ADDRESS (Street, city or town, state) <b>3712-38th Ave Cottage City, Md.</b>		DATE SIGNED <b>5-15-58</b>	
PHYSICIAN'S NAME (Type) <b>George Hageage</b>		Cottage City Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 19, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 21 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>			

2077231XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. MARITAL STATUS</p>		<p>8. DATE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESSES</p>		<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF FUNERAL HOME</p>	

6000

## CERTIFICATE OF DEATH

06036

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Ind</u> b. COUNTY <u>Pro Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Ind</u>		c. LENGTH OF STAY IN 1b <u>20 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4400 Holly Hill Rd -</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>NETTIE HARPER</u>		4. DATE OF DEATH <u>May 6, 1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 24 - 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Harper</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Hearst</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Paul Nystram</u>		Address <u>Hyattsville, Ind</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>2 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1, 1941</u> , to <u>May 6, 1958</u> ; that I last saw the deceased alive on <u>May 3, 1958</u> , and that death occurred at <u>9:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Waldo B. Moyers</u> M.D. <u>3503 Perry St. Mt. Rainier, Md.</u>		DATE SIGNED <u>5-8-58</u>	
PHYSICIAN'S NAME (Type) <u>Waldo B. Moyers</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5/9/58</u>	<u>Methodist Cemetery</u>	<u>Landsonville, Ind</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Sack's Sons - Hyattsville, Ind</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>MAY 12 '58</u>		<u>DePesch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director; page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6041

CERTIFICATE OF DEATH

06037

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b> d. STREET ADDRESS <b>26 Canary Rd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy Julius</b>		4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15-1958</b>
9. AGE (In years last birthday) yrs. <b>8</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>8</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Donald E. Julius</b>		14. MOTHER'S MAIDEN NAME <b>Winnie C. Winesgar</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity, Atelectasis</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Immaturity</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/15</b> , 19 <b>58</b> , to <b>5/15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5/15</b> , 19 <b>58</b> , and that death occurred at <b>9:15A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Francis Coane</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. F. Warren</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>6/5/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Cheverly, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr., Administrator</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 9 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Albert Leach</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6095 CERTIFICATE OF DEATH

06038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHILLUM</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CHILLUM, MARYLAND</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 830 Chillum Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>J.</u> Last <u>King</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>13th</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 2ND, 1874</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED DRESSMAKES</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>George King</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA RANDALL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. ANNIE ALLWINE - 830-Chillum Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized severe arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>June, 1952</u> , to <u>May 13, 1958</u> , that I last saw the deceased alive on <u>May 13, 1958</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel M. Bageant</u> M.D.				ADDRESS (Street, city or town, state) <u>5600 N.H. Ave Wash DC</u>			
DATE SIGNED <u>5/13/58</u>							
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-16-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louise Hinton</u>				ADDRESS <u>3831 E. Ave NW</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 19 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>							

CERTIFICATE OF DEATH

Form No. 10

<p>1. NAME OF DECEASED                  [REDACTED]</p>		<p>2. SEX                  [REDACTED]</p>		<p>3. AGE                  [REDACTED]</p>	
<p>4. DATE OF DEATH                  [REDACTED]</p>		<p>5. TIME OF DEATH                  [REDACTED]</p>		<p>6. PLACE OF DEATH                  [REDACTED]</p>	
<p>7. OCCUPATION                  [REDACTED]</p>		<p>8. CAUSE OF DEATH                  [REDACTED]</p>		<p>9. MANNER OF DEATH                  [REDACTED]</p>	
<p>10. SIGNATURE OF PHYSICIAN                  [REDACTED]</p>		<p>11. SIGNATURE OF REGISTRAR                  [REDACTED]</p>		<p>12. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>13. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>14. SIGNATURE OF NEXT OF KIN                  [REDACTED]</p>		<p>15. SIGNATURE OF CLERK                  [REDACTED]</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6042 CERTIFICATE OF DEATH

06039

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>md</u> b. COUNTY <u>Pro Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg md</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5353 Quincy Place</u>			d. STREET ADDRESS <u>5353 Quincy Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>LUCELLA PEARL KITCHEN</u>			4. DATE OF DEATH <u>MAY 4 1958</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 10, 1897</u>	9. AGE (In years lost birthday) <u>61</u> yrs.	IF UNDER 1 YEAR: Months <u>4</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u>58</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WHAT CHEER, IOWA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>WILLIARD A. JACKSON</u>			14. MOTHER'S MAIDEN NAME <u>MATILDA TRESSLER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>DAUGHTER - Velta Kitchen</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416X CORONARY THROMBOSIS</u> DUE TO (b) <u>RHEUMATIC HEART DISEASE</u> DUE TO (c) <u>CONGESTIVE HEART DISEASE</u>					INTERVAL BETWEEN ONSET AND DEATH <u>NONE</u> <u>12 YRS</u> <u>12 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. <u>19</u> Month, Day, Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>SEPT. 46</u> , 19 <u>46</u> to <u>MAY 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MAY 3</u> , 19 <u>58</u> , and that death occurred at <u>8 A.</u> M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>William T. Saccardi</u> M.D. <u>1150 Conn Ave</u>			ADDRESS (Street, city or town, state) <u>WASH. 6. D.C.</u>		
PHYSICIAN'S NAME (Type) <u>WILLIAM T. SACCARDI</u>			DATE SIGNED <u>MAY 4, 1958</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>May 8, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Salisbury City</u>	22d. LOCATION (City, town, or county) <u>Salisbury</u>	(State) <u>Missouri</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch</u>		ADDRESS <u>Sons Hyattsville Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 7 58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Saccardi</u>

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6001

CERTIFICATE OF DEATH

Reg. Dist. No.

06040

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>27 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>		15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1316 Ray Rd.</u>				d. STREET ADDRESS <u>1316 Ray Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Ellsworth</u> Last <u>Knorr</u>				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>12 Jan 1904</u>		9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u> Hours <u>13</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harry Knorr</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Roeder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-38-4073</u>		17. INFORMANT Address <u>Eleanor N Knorr 1316 Ray Rd. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized metastatic adenoma car-</u> DUE TO <u>cinoma sigmoid and Rectum</u> (c) <u>cinoma sigmoid and Rectum</u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Colostomy: May 1, 1955</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 May 1958</u> to <u>13 May 1958</u> , that I last saw the deceased alive on <u>12 May 1958</u> , and that death occurred at <u>10:58</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2200 R.I. Ave N.E. Wash. D.C.</u> DATE SIGNED <u>13 May 1958</u>							
ACTUAL SIGNATURE <u>Thomas E. Mathingly</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Thomas E. Mathingly, M.D. 2200 R.I. Ave N.E. Wash. D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-16-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Inc. Cleveland Ave. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>	

CERTIFICATE OF DEATH

Form No. 10

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH _____	
NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		RACE _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF REGISTRAR _____		SIGNATURE OF CLERK _____	

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICER IN THE DISTRICT WHERE THE DECEASED RESIDES.

# 1 8 M 00 I VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 6702 CERTIFICATE OF DEATH

Reg. Dist. No.

06041

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 West Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1702 Crosby Rd</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES LEON KRAFF</u>		4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-12-89</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Adam Krapf</u>		14. MOTHER'S MAIDEN NAME <u>Hanna Herb-</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Margaret Krapf</u>		Address <u>1702 Crosby Rd Hyattsville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Static Bronchopneumonia</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u> (c) <u>Nephrosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 months</u> <u>9 months</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>54</u> , to <u>May</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 27</u> , 19 <u>58</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph F. Patten</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>8641- Colesville Road 5/28/58</u>	
PHYSICIAN'S NAME (Type) <u>RALPH F. PATTEN</u>		<u>Silver Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-31-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Truckeeville Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deep Funeral Home</u>		ADDRESS <u>4812 Bu Ave</u>	
24a. REC'D BY REGISTRAR <u>ONE</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	
DATE <u>JUN 2 1958</u>			



CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF JURY

NAME OF JUDGE

NAME OF CLERK

NAME OF SHERIFF

NAME OF DEPUTY

NAME OF CONSTABLE

NAME OF TOWNSHIP CLERK

NAME OF COUNTY CLERK

NAME OF STATE CLERK

NAME OF FEDERAL CLERK

NAME OF MARSHAL

NAME OF DEPUTY MARSHAL

NAME OF SHERIFF DEPUTY

NAME OF CONSTABLE DEPUTY

NAME OF TOWNSHIP CLERK DEPUTY

NAME OF COUNTY CLERK DEPUTY

NAME OF STATE CLERK DEPUTY

NAME OF FEDERAL CLERK DEPUTY

NAME OF MARSHAL DEPUTY

NAME OF DEPUTY MARSHAL DEPUTY

NAME OF SHERIFF DEPUTY DEPUTY

NAME OF CONSTABLE DEPUTY DEPUTY

NAME OF TOWNSHIP CLERK DEPUTY DEPUTY

NAME OF COUNTY CLERK DEPUTY DEPUTY

NAME OF STATE CLERK DEPUTY DEPUTY

NAME OF FEDERAL CLERK DEPUTY DEPUTY

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6043

## CERTIFICATE OF DEATH

06042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Pg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel, Md</b>	
c. LENGTH OF STAY IN 1b <b>7 days</b>		d. STREET ADDRESS <b>106 Lafayette Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby Girl</b> Middle <b>Lonas</b> Last <b>Lonas</b>		4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-25-58</b>
9. AGE (In years last birthday) <b>7</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Bernard E. Lonas</b>	
14. MOTHER'S MAIDEN NAME <b>Louise R. Lonas</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Louise R. Lonas</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelasia</b> <b>762.5</b> DUE TO <b>Perinatal birth</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 25, 1958</b> to <b>May 2, 1958</b> , that I last saw the deceased alive on <b>May 1, 1958</b> and that death occurred at <b>1:28 AM</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Robert S. McCeney</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Robert S. McCeney, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>5/11/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital</b>
22d. LOCATION (City, town, or county) (State) <b>Cheverly, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr., Administrator.</b>		24a. REC'D BY REGISTRAR <b>MAY 19 58</b>	24b. REGISTRAR'S SIGNATURE <b>Al. Beach</b>

2077355XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH	
10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CLERGYMAN	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF CORONER	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF COUNTY CLERK		21. SIGNATURE OF TOWNSHIP CLERK	
22. SIGNATURE OF VILLAGE CLERK		23. SIGNATURE OF CITY CLERK		24. SIGNATURE OF COUNTY CLERK	
25. SIGNATURE OF STATE CLERK		26. SIGNATURE OF FEDERAL CLERK		27. SIGNATURE OF NATIONAL CLERK	
28. SIGNATURE OF INTERNATIONAL CLERK		29. SIGNATURE OF UNITED NATIONS CLERK		30. SIGNATURE OF WORLD CLERK	

## 6096 CERTIFICATE OF DEATH

Reg. Dist. No.

06043

1. PLACE OF DEATH o. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hill Crest Heights</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hill Crest Heights</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5811- 24th. Ave., S.E.</b>		d. STREET ADDRESS <b>5811- 24th. Ave., S.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>M.</b> Last <b>LOWE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>4th.</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18-1879</b>
9. AGE (In years last birthday) <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1897-1922</b>	
17. INFORMANT <b>Mrs. Amy V. Lowe</b>		Address <b>Same of # 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>332X</b> IMMEDIATE CAUSE (a) <b>cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis, generalized</b> DUE TO (c) <b>Left Paraplegia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>5 years</b> <b>9 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 5-4, 1958</b> to <b>May 4, 1958</b> that I last saw the deceased alive on <b>5-4, 1958</b> , and that death occurred at <b>3:05 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David S. Gordon</b> M.D.		ADDRESS (Street, city or town, state) <b>5731 23rd Parkway SE</b>	
PHYSICIAN'S NAME (Type) <b>DAVID S. GORDON</b>		DATE SIGNED <b>May 4-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 7-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Brothers</b>		ADDRESS <b>1661 Good Hope Road SE Washington, D.C.</b>	
24a. REC'D BY REGISTRAR <b>DATE MAY 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delayed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6044

Item 5. See: Birth Cert. et

## 6044 CERTIFICATE OF DEATH

06044

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Pg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md</b>		c. LENGTH OF STAY IN 1b <b>9Hrs. 18 Mins</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ann</b> Middle <b>Luers</b> Last <b>Luers</b>		4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-29-58</b>
9. AGE (In years last birthday) <b>9Hrs. 18 mins</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Bernard W Luers</b>	
14. MOTHER'S MAIDEN NAME <b>Valarie A Lancaster</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no none</b>	
16. SOCIAL SECURITY NO. <b>no none</b>		17. INFORMANT <b>Valarie Luers (Mother)</b> Address <b>Same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis</b> <b>762.5</b> DUE TO <b>Prematurity 33 wk</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity 33 wk</b> (c) <b>Prematurity 33 wk</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 29, 19 58</b> , to <b>May 29, 19 58</b> , that I last saw the deceased alive on <b>May 29, 19 58</b> , and that death occurred at <b>9:30 P. M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Robert Mc Ceney</b> M.D. ADDRESS (Street, city or town, state) <b>Laurel Md.</b> DATE SIGNED <b>5/30/58</b> PHYSICIAN'S NAME (Type) <b>Robert Mc Ceney</b> <b>Laurel Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/31/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24a. REC'D BY REGISTRAR <b>JUN 6 '58</b>	
ADDRESS <b>Hyattsville Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

2077323XV3

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Usual Residence		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Certificate		Place of Issuance		Official Seal	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06045

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>6045</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colmar Manor</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>3414 40th Place</b>			
3. NAME OF DECEASED (Type or print) <b>Elvin Meador Luskey</b>				4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1, 1879</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fireman</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William A. Luskey</b>				14. MOTHER'S MAIDEN NAME <b>Frances Scott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes; Sp. Amer. &amp; W.W.1</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mary Alice Luskey; same address as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Renal Disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 1, 1958</b>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-6-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Ft Myer, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home. Washington D.C.</b>				ADDRESS <b>Washington D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 5 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



6046

06047

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>29 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harry</b> First <b>N.</b> Middle <b>Mann</b> Last		4. DATE OF DEATH <b>May</b> Month <b>26</b> Day <b>58</b> Year <b>19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 3, 1906</b>
9. AGE (In years less birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>J E Mann</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>223 05 2124</b>	
17. INFORMANT <b>Mrs Katherine Mann</b> Address <b>Washington D. C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>1 year</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>7 days</b> <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>58</b> , to <b>May 26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 25</b> , 19 <b>58</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leon L Gallin</b>		ADDRESS (Street, city or town, state) <b>7206 Coleville Rd Hyattsville Md.</b>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>Leon L Gallin</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transportation 5/27/58</b>		22b. DATE THEREOF <b>5/27/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Keysville</b>		22d. LOCATION (City, town, or county) (State) <b>Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 28 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

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MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6047

## CERTIFICATE OF DEATH

Reg. Dist. No.

06048

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lotian	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS Box 52	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Martih		4. DATE OF DEATH Month May Day 24 Year 19 58	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 May 1958
9. AGE (In years lost birthday) yrs. 2		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Prince Georges Hosp U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Vermin Martin		14. MOTHER'S MAIDEN NAME Louise Sellman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Vermin Martin		Address Bristol Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 763.0 DUE TO Anoxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Interstitial Pneumonia (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 May, 1958, to 24 May, 1958, that I last saw the deceased alive on 24 May, 1958, and that death occurred at 3:50 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. R. Sasscer		DATE SIGNED 5-24-58	
PHYSICIAN'S NAME (Type) Dr. R. Sasscer, M.D.		ADDRESS (Street, city or town, state) Upper Marlboro, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-28-58	22c. NAME OF CEMETERY OR CREMATORY Moses Cemetery	22d. LOCATION (City, town, or county) (State) Dnewery Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm Reese #108 Wash St Annapolis		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
DATE MAY 27 '58		2077201XV7	

CERTIFICATE OF DEATH

MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BOSTON

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of interment		18. Signature of cremation		19. Signature of other disposition		20. Signature of other disposition	
21. Signature of other disposition		22. Signature of other disposition		23. Signature of other disposition		24. Signature of other disposition	
25. Signature of other disposition		26. Signature of other disposition		27. Signature of other disposition		28. Signature of other disposition	
29. Signature of other disposition		30. Signature of other disposition		31. Signature of other disposition		32. Signature of other disposition	
33. Signature of other disposition		34. Signature of other disposition		35. Signature of other disposition		36. Signature of other disposition	
37. Signature of other disposition		38. Signature of other disposition		39. Signature of other disposition		40. Signature of other disposition	
41. Signature of other disposition		42. Signature of other disposition		43. Signature of other disposition		44. Signature of other disposition	
45. Signature of other disposition		46. Signature of other disposition		47. Signature of other disposition		48. Signature of other disposition	
49. Signature of other disposition		50. Signature of other disposition		51. Signature of other disposition		52. Signature of other disposition	
53. Signature of other disposition		54. Signature of other disposition		55. Signature of other disposition		56. Signature of other disposition	
57. Signature of other disposition		58. Signature of other disposition		59. Signature of other disposition		60. Signature of other disposition	
61. Signature of other disposition		62. Signature of other disposition		63. Signature of other disposition		64. Signature of other disposition	
65. Signature of other disposition		66. Signature of other disposition		67. Signature of other disposition		68. Signature of other disposition	
69. Signature of other disposition		70. Signature of other disposition		71. Signature of other disposition		72. Signature of other disposition	
73. Signature of other disposition		74. Signature of other disposition		75. Signature of other disposition		76. Signature of other disposition	
77. Signature of other disposition		78. Signature of other disposition		79. Signature of other disposition		80. Signature of other disposition	
81. Signature of other disposition		82. Signature of other disposition		83. Signature of other disposition		84. Signature of other disposition	
85. Signature of other disposition		86. Signature of other disposition		87. Signature of other disposition		88. Signature of other disposition	
89. Signature of other disposition		90. Signature of other disposition		91. Signature of other disposition		92. Signature of other disposition	
93. Signature of other disposition		94. Signature of other disposition		95. Signature of other disposition		96. Signature of other disposition	
97. Signature of other disposition		98. Signature of other disposition		99. Signature of other disposition		100. Signature of other disposition	

6097

## CERTIFICATE OF DEATH

Reg. Dist. No.

06049

1. PLACE OF DEATH a. COUNTY <b>Prince George's County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kent Village Md</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Solomons</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7331 Forest Road</b>		d. STREET ADDRESS <b>---</b>	
3. NAME OF DECEASED (Type or print) First <b>Emily</b> Middle <b>Elizabeth</b> Last <b>Martin</b>		4. DATE OF DEATH Month <b>May</b> Day <b>29</b> , Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1896</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>04</b> Days <b>X</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Peter Streukens</b>		14. MOTHER'S MAIDEN NAME <b>Emma ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Mrs Joseph Schmidt</b>		Address <b>Kent Village Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma uteris</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Colon</b> DUE TO (c) <b>Burns</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Burns</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mon. 19, 1958</b> to <b>Wed. 29, 1958</b> , that I last saw the deceased alive on <b>Wed. 19, 1958</b> , and that death occurred at <b>8:55 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Irvin H. Grass Green</b>		ADDRESS (Street, city or town, state) <b>3101 Arundel Rd</b>	
PHYSICIAN'S NAME (Type) <b>IRVIN H. GRASS GREEN</b>		DATE SIGNED <b>3-29-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 31, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Our Lady Star of the Sea</b>		22d. LOCATION (City, town, or county) (State) <b>Solomons - Calvert Co - Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. B. Harkness &amp; Son - Mutual Fund</b>		24a. REC'D BY REGISTRAR <b>JUN 2 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>W. E. Leach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of Deceased: <u>John Doe</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>	
<p>4. Date of Death: <u>Jan 15 1950</u></p>	
<p>5. Place of Death: <u>Home</u></p>	
<p>6. Cause of Death: <u>Heart Disease</u></p>	
<p>7. Signature of Physician: <u>Dr. J. Smith</u></p>	
<p>8. Signature of Registrar: <u>John Doe</u></p>	
<p>9. Date of Registration: <u>Jan 16 1950</u></p>	
<p>10. Place of Registration: <u>Baltimore</u></p>	
<p>11. Name of Hospital: <u>St. Mary's</u></p>	
<p>12. Name of Doctor: <u>Dr. J. Smith</u></p>	
<p>13. Name of Nurse: <u>Miss. J. Doe</u></p>	
<p>14. Name of Undertaker: <u>John Doe</u></p>	
<p>15. Name of Burial Place: <u>St. Mary's</u></p>	
<p>16. Name of Burial Place: <u>St. Mary's</u></p>	
<p>17. Name of Burial Place: <u>St. Mary's</u></p>	
<p>18. Name of Burial Place: <u>St. Mary's</u></p>	
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<p>98. Name of Burial Place: <u>St. Mary's</u></p>	
<p>99. Name of Burial Place: <u>St. Mary's</u></p>	
<p>100. Name of Burial Place: <u>St. Mary's</u></p>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6048 CERTIFICATE OF DEATH

Reg. Dist. No. 06050

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 27 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Hgts.				X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 710 59th Place			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Ruth Martin				4. DATE OF DEATH Month May Day 10 Year 19 58			
5. SEX Female		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 Jan 1922	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Walter Spriggs				14. MOTHER'S MAIDEN NAME Dallis Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT Edna Spriggs 725-61st Ave N.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X Carcinomatosis DUE TO (b) Ca of cervix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 13, 1957, to May 10, 1958, that I last saw the deceased alive on May 9, 1958, and that death occurred at 8:35 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Francis Warren M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5-14-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington W.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington ADDRESS 467 N st. N. W.				24. REC'D BY REGISTRAR DATE MAY 15 '58		25. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 12

DATE OF DEATH

PLACE

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

SEX

CAUSE OF DEATH

PLACE

DATE

DATE OF BIRTH

PLACE OF BIRTH

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SEX

AGE

PLACE OF BIRTH

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DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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PLACE OF DEATH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06051

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Maryland</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham Maryland</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>6016 Naval avenue, .</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Roland Harry Mathews</b>			4. DATE OF DEATH Month Day Year <b>May 18, 1958</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 19, 1917</b>	9. AGE (In years last birthday) <b>40</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <b>24</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boiler repair man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>P E P Electric co</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			13. FATHER'S NAME <b>Barker A Mathews</b>		
14. MOTHER'S MAIDEN NAME <b>Cecelia Adams</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>yes W W II</b>		
16. SOCIAL SECURITY NO. <b>577-01-5755</b>			17. INFORMANT <b>Anna R Mathews</b> Address <b>Lanham, Maryland.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>490x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Lobar pneumonia</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fatty degeneration of liver</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL <input checked="" type="checkbox"/> OR CREMATION <input type="checkbox"/> <b>Burial</b>		22b. DATE THEREOF <b>5/22/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b>		22e. REC'D BY REGISTRAR <b>May 20 '58</b>		22f. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co, 2901 14th St. N.W. Wasn, DC</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE  
DEPT



RECEIVED  
JAN 10 1950

RECEIVED  
JAN 10 1950

RECEIVED  
JAN 10 1950

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1950

1. Name of Deceased: John T. Kavanagh

2. Date of Death: Jan 10, 1950

3. Place of Death: Home

4. Age: 65

5. Sex: Male

6. Race: White

7. Marital Status: Married

8. Occupation: None

9. Cause of Death: Coronary atherosclerosis

10. Manner of Death: Natural

11. Signature of Medical Examiner: John T. Kavanagh

12. Date of Signature: Jan 10, 1950

13. Signature of Coroner: John T. Kavanagh

14. Date of Signature: Jan 10, 1950

15. Signature of Registrar: John T. Kavanagh

16. Date of Signature: Jan 10, 1950

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66052

6050

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chertsey		c. LENGTH OF STAY IN 1b 36		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capital Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 14801-H Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) George Henry Maurer			4. DATE OF DEATH May 17 1958		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Aug 8, 1872	
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Skilled laborer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY U.S.		13. FATHER'S NAME George Henry Maurer Jr.		14. MOTHER'S MAIDEN NAME Henrietta Tucker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Miriam L. Beall	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X Congestive heart failure DUE TO (b) Labor pneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED May 18, 1958	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-21-58		22c. NAME OF CEMETERY OR CREMATORY North Creek	
22d. LOCATION (City, town, or county) Wash D C		22e. (State)		23. FUNERAL DIRECTOR'S SIGNATURE Lee Howard H. McMillan	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		DATE MAY 19 '58	





1914

RECEIVED  
STATE DEPT. OF HEALTH  
JAN 10 1914

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Faint text, possibly "John Doe"]

2. AGE: [Faint text, possibly "45"]

3. SEX: [Faint text, possibly "Male"]

4. OCCUPATION: [Faint text, possibly "Teacher"]

5. PLACE OF BIRTH: [Faint text, possibly "Maryland"]

6. DATE OF DEATH: [Faint text, possibly "Jan 10 1914"]

7. TIME OF DEATH: [Faint text, possibly "10:00 AM"]

8. CAUSE OF DEATH: [Faint text, possibly "Heart Disease"]

9. DISEASE OR INJURY: [Faint text, possibly "Myocardial Infarction"]

10. SIGNATURE OF EXAMINER: [Faint signature]

11. SIGNATURE OF ATTENDING PHYSICIAN: [Faint signature]

12. SIGNATURE OF CORONER: [Faint signature]

13. SIGNATURE OF JURY: [Faint signature]

14. SIGNATURE OF WITNESSES: [Faint signature]

15. SIGNATURE OF DECEASED: [Faint signature]

16. SIGNATURE OF NEXT OF KIN: [Faint signature]

17. SIGNATURE OF MINISTER OF THE GOSPEL: [Faint signature]

18. SIGNATURE OF CHURCH CLERK: [Faint signature]

19. SIGNATURE OF BURIAL PLACE: [Faint signature]

20. SIGNATURE OF FUNERAL HOME: [Faint signature]

21. SIGNATURE OF CEMETERY: [Faint signature]

22. SIGNATURE OF INTERMENT: [Faint signature]

23. SIGNATURE OF BURIAL: [Faint signature]

24. SIGNATURE OF CREMATION: [Faint signature]

25. SIGNATURE OF OTHER: [Faint signature]

Items 3,8,9 &amp; 14, Film G-230 6/23/58, cas

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G229 5-29-58 et

Reg. Dist. No.

C6046

6051

FOR STATE  
HEALTH DEPT.1. PLACE OF DEATH  
a. COUNTY

Prince Georges

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Pr. Geo.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Laurel

c. LENGTH OF STAY IN 1b

5 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Laurel

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

811 Maple Avenue

d. STREET ADDRESS

811 Maple Avenue

e. IS RESIDENCE  
ON A FARM?YES ☐ NO ☒3. NAME OF  
DECEASED  
(Type or print)

First

Percy

Middle

Sylvester

Last

Mack McCoy

4. DATE  
OF  
DEATH

Month

May

Day

18

Year

19 58

## 5. SEX

Male

## 6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

## 8. DATE OF BIRTH

July 5, 1909

9. AGE (In years  
last birthday)

47 48 yrs.

## IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Laborer

## 10b. KIND OF BUSINESS OR INDUSTRY

Agric. Research

## 11. BIRTHPLACE (State or foreign country)

Maryland

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Walter Winfield Mack

## 14. MOTHER'S MAIDEN NAME

Grace Madelene Adams Solomon

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

(If yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

Address

Dorothy M. Adams; 618 10th St. Laurel, Md.

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Cardiovascular renal disease

442X

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN  
ONSET AND DEATH19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS  
PRIMARY ☐ or CONTRIBUTING ☐  
CAUSE OF DEATH.

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour o. m.  
p. m.20d. INJURY OCCURRED  
While of work ☐ Not while  
of work ☐20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my  
opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

John T. Maloney

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S  
NAME (Type)

John T. Maloney, M.D.

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

May 18, 1958

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

## 22b. DATE THEREOF

## 22c. NAME OF CEMETERY OR CREMATORY

## 22d. LOCATION (City, town, or county)

(State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

## 24a. REC'D BY REGISTRAR

## 24b. REGISTRAR'S SIGNATURE

DATE MAY 21 '58

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

Burial May 11/58 Becons Chapel Anne Arundel Co., Md  
Ridgely Selby 401 Wash St  
Laurel Md

FOR STATE  
HEALTH DEPT.



0-81

James Douglas

James Douglas

1000

James Douglas

James Douglas

211 Maple Avenue

211 Maple Avenue

James Douglas

James Douglas

July 1, 1911

James Douglas

1000

James Douglas

James Douglas

James Douglas

James Douglas

James Douglas

James Douglas

James Douglas

James Douglas

James Douglas

James Douglas

James Douglas

James Douglas

James Douglas

James Douglas

James Douglas

James Douglas

James Douglas

James Douglas

James Douglas

James Douglas

REGISTRATION

May 18, 1911

John F. Johnson

James Douglas

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6003

CERTIFICATE OF DEATH

06053

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georgies</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pri. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville Md.,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Home</b>				d. STREET ADDRESS <b>5805-Queens Chapel, Hyattsville</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Geraldine Marie McNerhany</b>				4. DATE OF DEATH Month Day Year <b>5 1 19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 25, 1866</b>	9. AGE (In years last birthday) yrs. <b>91</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Gov't Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John McNerhany</b>				14. MOTHER'S MAIDEN NAME <b>Rachael Ann Maguire</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Joseph LaPlaca-914-Kearny St. N.E.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO <b>Cardio Vascular Renal Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic</b> DUE TO (c) <b>Chronic</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>7 May 1958</b>	
20f. (City or town) <b>Washington, D. C.</b>				20g. (County) <b>Washington, D. C.</b>			
20h. (State) <b>D. C.</b>				20i. (Country) <b>U. S. A.</b>			
21. I certify that I attended the deceased from <b>July 17, 1958</b> to <b>July 17, 1958</b> , that I last saw the deceased alive on <b>April 17, 1958</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1222 - Monroe St., N. E. Wash., D.C.</b> DATE SIGNED <b>Robert R. Hottel</b>							
ACTUAL SIGNATURE <b>Robert R. Hottel</b> M.D.				1222 - Monroe St., N. E. Wash., D.C.			
PHYSICIAN'S NAME (Type) <b>Robert R. Hottel</b>				1222 - Monroe Street, N. E. Wash., D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>May 3, 1958</b>		22b. DATE THEREOF <b>May 3, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Alfred</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

CERTIFICATE OF DEATH

B-3

REG. NO. 100

<p>1. NAME OF DECEASED                  MARY ANN GOSWICK</p>		<p>2. SEX                  FEMALE</p>	
<p>3. AGE                  72</p>		<p>4. DATE OF DEATH                  JANUARY 1, 1900</p>	
<p>5. PLACE OF DEATH                  HOME - 1000 - 1000 - 1000</p>		<p>6. CAUSE OF DEATH                  OLD AGE</p>	
<p>7. PLACE OF BIRTH                  NEW YORK</p>		<p>8. OCCUPATION                  HOUSEWIFE</p>	
<p>9. NAME OF MOTHER                  MARY ANN GOSWICK</p>		<p>10. NAME OF FATHER                  JOHN GOSWICK</p>	
<p>11. NAME OF SPOUSE                  JOHN GOSWICK</p>		<p>12. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>13. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>14. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>15. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>16. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>17. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>18. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>19. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>20. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>21. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>22. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>23. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>24. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>25. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>26. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>27. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>28. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>29. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>30. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>31. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>32. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>33. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>34. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>35. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>36. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>37. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>38. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>39. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>40. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>41. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>42. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>43. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>44. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>45. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>46. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>47. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>48. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>49. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>50. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>51. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>52. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>53. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>54. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>55. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>56. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>57. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>58. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>59. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>60. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>61. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>62. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>63. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>64. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>65. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>66. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>67. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>68. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>69. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>70. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>71. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>72. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>73. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>74. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>75. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>76. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>77. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>78. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>79. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>80. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>81. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>82. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>83. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>84. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>85. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>86. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>87. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>88. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>89. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>90. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>91. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>92. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>93. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>94. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>95. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>96. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>97. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>98. NAME OF PREVIOUS SPOUSE                  NONE</p>	
<p>99. NAME OF PREVIOUS SPOUSE                  NONE</p>		<p>100. NAME OF PREVIOUS SPOUSE                  NONE</p>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>34</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Ignacious Miller</b>		4. DATE OF DEATH Month Day Year <b>May 18 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 19, 1881</b>
9. AGE (In years by birthday) <b>77</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Custodian</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Wm. Miller</b>	
14. MOTHER'S MAIDEN NAME <b>Anne Luber</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Theodore Howe; College Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>442x</b> DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>May 18, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-21-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		24a. REC'D BY REGISTRAR <b>May 21 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>		24c. ADDRESS <b>3821 14th. St. N. W.</b>	

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <b>John T. Adams, M.D.</b>		DATE OF DEATH <b>May 16, 1958</b>	
AGE <b>45</b>		SEX <b>Male</b>	
RACE <b>White</b>		MARITAL STATUS <b>Married</b>	
BIRTH DATE <b>Jan. 15, 1913</b>		BIRTH PLACE <b>Washington, D.C.</b>	
EDUCATION <b>High School</b>		OCCUPATION <b>Physician</b>	
RESIDENCE <b>3704 Calvary Street</b>		CITY <b>Baltimore</b>	
STATE <b>Md.</b>		ZIP CODE <b>21218</b>	
CAUSE OF DEATH <b>Cardiovascular renal disease</b>		MANNER OF DEATH <b>Home</b>	
IMMEDIATE CAUSE OF DEATH <b>Myocardial infarction</b>		UNDERLYING CAUSE OF DEATH <b>Chronic glomerulonephritis</b>	
MORBIDITY <input checked="" type="checkbox"/> Yes		MORTALITY <input checked="" type="checkbox"/> Yes	
SIGNATURE OF PHYSICIAN <b>John T. Adams, M.D.</b>		DATE <b>May 16, 1958</b>	
SIGNATURE OF MEDICAL EXAMINER <b>John T. Adams, M.D.</b>		DATE <b>May 16, 1958</b>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06055**

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>	c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>25 Riverdale</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		d. STREET ADDRESS <b>4700 Oliver Street</b>	
3. NAME OF DECEASED (Type or print) <b>Filippo M. Monaco</b>		4. DATE OF DEATH Month <b>May</b> Day <b>14</b> , Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-22-1881</b>
9. AGE (in years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Landlord</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rooming Houses</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Angelo Monaco</b>		14. MOTHER'S MAIDEN NAME <b>Lucia Macaroni</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Anthony Romano; 1125 Varnum St., Wash., D.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Colmar Manor, Md.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>May 14, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 17, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 19 '58</b>	
ADDRESS <b>Hyattsville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NOT STATE  
HEALTH DEPT

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Education		Residence		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness	
John F. Kennedy		35		Male		White		White		Catholic		Single		President of the United States		High School		Washington, D.C.		November 22, 1963		Washington, D.C.		Assassination		Homicide		John F. Kennedy		John F. Kennedy		John F. Kennedy		John F. Kennedy	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06056

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <b>6954</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chantilly</u>		c. LENGTH OF STAY IN 1b <u>Weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>16809-7 street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ralph Bernard Morrow</u>				4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 27, 1895</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ray E. Morrow</u>				14. MOTHER'S MAIDEN NAME <u>Olney Jane Becking</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>yes WWII</u>		16. SOCIAL SECURITY NO. <u>100-1</u>		17. INFORMANT <u>Carl Allen Morrow, Father</u>		Address <u>Box 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>May 15, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>5-15-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shiloh Funeral Home</u>		22d. LOCATION (City, town, or county) (State) <u>York</u> <u>Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Basch's Sons Hyattsville Md.</u>				24a. REC'D BY REGISTRAR <u>MAY 15 58</u>		24b. REGISTRAR'S SIGNATURE <u>Ch. Search</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

0181

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Usual Residence		7. Cause of Death		8. Manner of Death	
9. Occupation		10. Education		11. Marital Status		12. Social History	
13. Medical History		14. Present Illness		15. Post-mortem Examination		16. Signature of Examiner	
17. Signature of Physician		18. Signature of Coroner		19. Signature of Medical Examiner		20. Signature of Registrar	

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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77  
BALTIMORE, 18  
Item 8, Film G229, 5/21/58  
6955  
CERTIFICATE OF DEATH

Reg. Dist. No. 06057

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		d. STREET ADDRESS Rt. 1 Box X 1 350	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jerome Mosby		4. DATE OF DEATH Month Day Year May 10 19 58	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Oct. 1957
9. AGE (In years lost birthday) yrs. 18		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington DC		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Raymond Webb		14. MOTHER'S MAIDEN NAME Beatrice mosby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-9-58, 19, to 5-10-58, 19, that I lost saw the deceased olive on 5-9-58, 19, and that death occurred at 12 10AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Beulah W. Jenkins</i> M.D.			
PHYSICIAN'S NAME (Type) Dr. Van Gelderan			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/14/58	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE Johnson & Jenkins		24a. REC'D BY REGISTRAR DATE MAY 15 1958	
ADDRESS 4804 Ga. ave. NW		24b. REGISTRAR'S SIGNATURE C. L. Bouch	

CERTIFICATE OF DEATH

Page One of Two

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

PERMANENT CAUSE OF DEATH

PERMANENT CAUSE OF DEATH

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PERMANENT CAUSE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6956

## CERTIFICATE OF DEATH

06058

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>34 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Madison</b> Last <b>Myrick</b>		4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 Oct. 1906</b>
9. AGE (In years last birthday) yrs. <b>51</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>18</b> Hours <b>58</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>	
11. BIRTHPLACE (State or foreign country) <b>Chattham Co., N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clay Myrick</b>		14. MOTHER'S MAIDEN NAME <b>Martha A. Thrower</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Mrs. Olive C. Myrick,</b>		Address <b>8411 48th Ave., College Pk., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive St. Hemorrhage</b> <b>581.0</b> DUE TO <b>Portul Cerebro-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Portul Cerebro-</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>3 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Date nature of injury in Part I or Part II of item 18.) <b>4</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 14, 19 58</b> to <b>May 18, 19 58</b> , that I last saw the deceased alive on <b>May 17, 19 58</b> , and that death occurred at <b>5,30A M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Hans Wodak</b>		ADDRESS (Street, city or town, state) <b>30-C RIDGE RD GREENBELT, MD</b> DATE SIGNED <b>5-18-58</b>	
PHYSICIAN'S NAME (Type) <b>HANS WODAK, M.D.</b>		<b>30-C Ridge Road, Greenbelt, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/21/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Handersburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. Buindale Md.</b>		ADDRESS <b>30-C Ridge Road, Greenbelt, Md.</b>	
24a. REC'D BY REGISTRAR <b>W. W. Chambers</b>		24b. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>	

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
MARRIED		WIDOW		SINGLE		DIVORCED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		COUNTY		STATE	
MARRIED		WIDOW		SINGLE		DIVORCED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		COUNTY		STATE	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY	
JANUARY 1, 1920		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		JANUARY 1, 1920		BALTIMORE		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY	
JANUARY 1, 1920		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		JANUARY 1, 1920		BALTIMORE		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06059

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN lb <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Sen Hosp</u>			d. STREET ADDRESS <u>Hyattsville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Donald</u> Last <u>Wash</u>			4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-40</u>		9. AGE (In years last birthday) <u>17</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Schoolboy</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Wilbur J. Wash</u>		
14. MOTHER'S MAIDEN NAME <u>Katherine T. Rublerforth</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Wilbur J. Wash; same address</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration of food</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lost control of automobile which rolled over -</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>5-48</u> <u>5-25</u> <u>1958</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
20f. (City or town) <u>Kentland - Pr. Geo - Md.</u>		20g. (County) <u>Pr. Geo</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John J. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/29/58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	
22d. LOCATION (City, town, or county) <u>Calmar Manor Md</u>		22e. (State) <u>Md</u>		22f. REC'D BY REGISTRAR <u>27 '58</u>	
22g. REGISTRAR'S SIGNATURE <u>27 '58</u>		22h. REGISTRAR'S SIGNATURE		22i. REGISTRAR'S SIGNATURE	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Wm Lee's Sons Co 300-4th St N.E.</u>					
24. ADDRESS <u>27 '58</u>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6004

CERTIFICATE OF DEATH

Reg. Dist. No.

06060

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4922 40th Place		d. STREET ADDRESS 4922 40th Place,,	
3. NAME OF DECEASED (Type or print) First Middle Last Narcissa G Norton		4. DATE OF DEATH Month Day Year May 13, 1958 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 10, 1883
9. AGE (In years last birthday) 74		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Albert Money		14. MOTHER'S MAIDEN NAME Nancy Peacock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT John B Norton		Address Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X Carcinoma of Head of Pancreas DUE TO with metastases to liver (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 6 mo. +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-19, 1957, to 5-13, 1958, that I last saw the deceased alive on 5-12, 1958, and that death occurred at 1:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Waldo B. Moyers M.D. 3503 Perry St. 574-56			
ACTUAL SIGNATURE Waldo B. Moyers		PHYSICIAN'S NAME (Type) Waldo B. Moyers	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/15/58	
22c. NAME OF CEMETERY OR CREMATORY Lewinsville Cemetery		22d. LOCATION (City, town, or county) (State) Lewinsville Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE MAY 19 '58		24b. REGISTRAR'S SIGNATURE Alfred...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Certificate		Time of Certificate		Place of Certificate	
Signature of Medical Examiner		Signature of Pathologist		Signature of Anatomist	
Signature of Surgeon		Signature of Dentist		Signature of Pharmacist	
Signature of Nurse		Signature of Midwife		Signature of Undertaker	
Signature of Burial		Signature of Cremation		Signature of Other	
Signature of Family		Signature of Friends		Signature of Community	
Signature of Church		Signature of School		Signature of Other	
Signature of State		Signature of Federal		Signature of International	
Signature of Local		Signature of Regional		Signature of National	
Signature of World		Signature of Universe		Signature of God	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06061

6098

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

M

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmount Heights</b> c. LENGTH OF STAY IN 1b <b>transient</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5720 Jay Street</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>226 12 Street, S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>Corine E. Palmer</b> First Middle Last <b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>colored</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>1-13-19</b> <b>9. AGE</b> (In years last birthday) <b>39</b> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		<b>4. DATE OF DEATH</b> <b>May 12, 19 58</b> Month Day Year			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clerk</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Center Market</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Virginia</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Sam Kite</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Mamie Strother</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> _____ <b>17. INFORMANT</b> <b>Mamie Kite; same address as # 2.</b> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO (b) <b>Shotgun wounds of arm and chest.</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Shot by a gun held by another person.</b>			
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>May 12 19 58</b> Hour o. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Home</b> <b>20f. (City or town) (County) (State)</b> <b>Fairmount Heights, Pr. Geo. Md.</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input checked="" type="checkbox"/>, Undetermined manner <input type="checkbox"/></b>					
<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i> <b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>May 12, 1958</b> DATE SIGNED			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b> <b>22b. DATE THEREOF</b> <b>5-17-58</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>LINCOLN MEMORIAL</b> <b>22d. LOCATION (City, town, or county) (State)</b> <b>4001 SUTLAND RD. S.E. Md.</b>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>B.F. TAYLOR FUNERAL HOME INC.</b> <b>ADDRESS</b> <b>1702 12TH ST. N.W.</b> <b>24a. REC'D BY REGISTRAR</b> <b>DATE MAY 19 '58</b> <b>24b. REGISTRAR'S SIGNATURE</b> <i>W. H. ...</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 of this Medical Examiner's Certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06062

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. LENGTH OF STAY IN 1b Heslop Avenue X Seat Pleasant Md	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Edward Payne		4. DATE OF DEATH May 26, 1958- 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 12, 1906
9. AGE (in years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineering		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Lynn Payne		14. MOTHER'S MAIDEN NAME Virginia Eye	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579 02 4772	
17. INFORMANT Bertha L Payne		Address Seat Pleasant, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiorespiratory renal disease [a], stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 26, 1958	
DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-29-58	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Haulow		ADDRESS 3831-GA. AVE. N.W.	
24a. REC'D BY REGISTRAR JUN 2 '58		24b. REGISTRAR'S SIGNATURE W. J. Leach	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
John Doe		45		Male		White		1945		Home	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		TIME OF DEATH		TEMPERATURE	
123 Main St.		Teacher		Heart Disease		Natural		10:00 AM		Normal	
PREVIOUS ILLNESS		MEDICAL HISTORY		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS	
None		None		None		None		None		None	
SIGNATURE OF EXAMINER		DATE		SIGNATURE OF DECEASED		DATE		SIGNATURE OF WITNESS		DATE	
[Signature]		1945		[Signature]		1945		[Signature]		1945	

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Halen</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Penn Grove</u> 69X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. STREET ADDRESS <u>37 East Main St</u>	
3. NAME OF DECEASED (Type or print) <u>Henry James Peak</u>		4. DATE OF DEATH <u>May 4</u> 1958	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1893</u> 65 yrs.
9. AGE (In years last birthday) <u>65</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemical Operator Duponts</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New Jersey</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lamar Peak</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Neitch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>145-07-7388</u>	
17. INFORMANT <u>Leo Peak, Carney Point N.J.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/7/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lawnside</u>		22d. LOCATION (City, town, or county) (State) <u>Woodstown N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Basch's Sons</u>		24a. REC'D BY REGISTRAR <u>Albrecht</u>	
ADDRESS <u>Hyattsville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>May 4, 1958</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

5

MASSACHUSETTS DEPARTMENT OF HEALTH-BALDWIN 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Faint, mostly illegible handwritten text and printed form fields are visible across the page. The form appears to be a standard medical certificate with sections for patient information, cause of death, and examiner details.]*



6060

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Albert V Polyanski</b>		4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 July 1919</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Reuben L. Polyanski</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Myers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-05-2064</b>	
17. INFORMANT <b>Mrs C. Mae Polyanski- Wife- same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Haemorrhagic Pancreatitis</b> <b>587.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>acute Pulmonary edema, shock</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> , 19____, to <b>24 May</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>23 May</b> , 19 <b>58</b> , and that death occurred at <b>4:40 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leon L. Gallin</b>		ADDRESS (Street, city or town, state) <b>7200 Calverville Rd. W. Hyattsville Md</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Leon Gallin, M.D.</b>		DATE SIGNED <b>24 May</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 28, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Our Lady of the Fields</b>		22d. LOCATION (City, town, or county) (State) <b>Millersville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>		ADDRESS <b>Annapolis, Maryland</b>	
24a. REC'D BY REGISTRAR <b>W. Hyattsville</b>		24b. REGISTRAR'S SIGNATURE <b>W. Hyattsville</b>	
DATE <b>MAY 28 '58</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6000

Form 100-10

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Date of birth: \_\_\_\_\_

4. Place of birth: \_\_\_\_\_

5. Date of death: \_\_\_\_\_

6. Place of death: \_\_\_\_\_

7. Cause of death: \_\_\_\_\_

8. Signature of physician: \_\_\_\_\_

9. Signature of registrar: \_\_\_\_\_

10. Signature of informant: \_\_\_\_\_

11. Signature of witness: \_\_\_\_\_

12. Signature of funeral director: \_\_\_\_\_

13. Signature of coroner: \_\_\_\_\_

14. Signature of justice of the peace: \_\_\_\_\_

15. Signature of health officer: \_\_\_\_\_

16. Signature of medical examiner: \_\_\_\_\_

17. Signature of pathologist: \_\_\_\_\_

18. Signature of anatomist: \_\_\_\_\_

19. Signature of bacteriologist: \_\_\_\_\_

20. Signature of virologist: \_\_\_\_\_

21. Signature of epidemiologist: \_\_\_\_\_

22. Signature of public health nurse: \_\_\_\_\_

23. Signature of health department: \_\_\_\_\_

24. Signature of state health department: \_\_\_\_\_

25. Signature of federal health department: \_\_\_\_\_

26. Signature of international health department: \_\_\_\_\_

27. Signature of world health organization: \_\_\_\_\_

28. Signature of united nations: \_\_\_\_\_

29. Signature of world bank: \_\_\_\_\_

30. Signature of international labor organization: \_\_\_\_\_

31. Signature of world health conference: \_\_\_\_\_

32. Signature of world health assembly: \_\_\_\_\_

33. Signature of world health council: \_\_\_\_\_

34. Signature of world health commission: \_\_\_\_\_

35. Signature of world health committee: \_\_\_\_\_

36. Signature of world health bureau: \_\_\_\_\_

37. Signature of world health center: \_\_\_\_\_

38. Signature of world health office: \_\_\_\_\_

39. Signature of world health department: \_\_\_\_\_

40. Signature of world health ministry: \_\_\_\_\_

41. Signature of world health government: \_\_\_\_\_

42. Signature of world health parliament: \_\_\_\_\_

43. Signature of world health congress: \_\_\_\_\_

44. Signature of world health conference: \_\_\_\_\_

45. Signature of world health assembly: \_\_\_\_\_

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6005 CERTIFICATE OF DEATH

06065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>same</u> b. COUNTY <u>P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>4104 Jefferson</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROBERT GILLIAM PORTER</u>		4. DATE OF DEATH <u>MAY 27 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 1, 1898</u>
9. AGE (In years, last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sales representative Washington Ins Co</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wm. H. Porter</u>	
14. MOTHER'S MAIDEN NAME <u>Mary E. Lorker</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>yes</u> (Yes, no, or unknown) <u>WW I</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>214-01-0314</u>		17. INFORMANT <u>Mary E. Porter Hyattsville Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis with</u> <u>420.1</u> DUE TO <u>Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> (c) <u>Severalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 5, 1958</u> to <u>May 27, 1958</u> that I last saw the deceased alive on <u>May 20, 1958</u> and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. L. Etienne</u> M.D.		ADDRESS (Street, city or town, state) <u>4713 - Berwyn Rd</u> DATE SIGNED <u>5/28/58</u>	
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>5/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
22d. LOCATION (City, town, or county) <u>Arlington</u> (State) <u>Pa</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gusche Sons Hyattsville Md</u> ADDRESS	
24a. REC'D BY REGISTRAR <u>JUN 2 58</u>		24b. REGISTRAR'S SIGNATURE <u>Albee</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The laws require that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF JUSTICE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6061

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS 7507 Girard Street,.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Richard Knowlton Preston			4. DATE OF DEATH Month May Day 2, Year 19 58		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 30, 1957		9. AGE (In years last birthday) yrs. 8 Months 1 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY U S A					
13. FATHER'S NAME Richard Knowlton Preston, Sr			14. MOTHER'S MAIDEN NAME Stewart Thersa Berry		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Richard Knowlton Preston Sr College Park, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Acute congestive heart failure DUE TO (b) Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		May 3, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 5, 1958		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	
				22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			ADDRESS Hyattsville, Md.		
24a. REC'D BY REGISTRAR MAY 7 '58		24b. REGISTRAR'S SIGNATURE R. J. Leach			

2077212XV6

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06067

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pt. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>	c. LENGTH OF STAY IN 1b <u>20 G</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen Hosp</u>		e. STREET ADDRESS <u>P.O. Box 272 Sanham Pl.</u>	
3. NAME OF DECEASED (Type or print) <u>Clifford</u> First <u>Raines</u> Middle <u>Reed</u> Last	4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1958</u>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-28-79</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u>	11. IF UNDER 24 HRS. Hours <u>2</u> Min. <u>58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Govt Employee Sanatorium</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>	
11. BIRTHPLACE (State of foreign country) <u>U.S.G.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.G.</u>	
13. FATHER'S NAME <u>Louis Johnson Reed</u>		14. MOTHER'S MAIDEN NAME <u>Mary Rainis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>126-10-220</u>	
17. INFORMANT <u>Louis Henry Reed</u>		Address <u>Same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage &amp; shock</u> <u>976x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Gunshot wounds abdomen</u> (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted wounds</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>5-28-58</u> p. m. <u>58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. City or town (County) (State) <u>Bowie - Pt. Geo - Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John D. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5-28-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Burial June 1, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Canandaigua N. Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McNitt Candlish Laurel Md</u>		24a. REC'D BY REGISTRAR <u>JUN 2 58</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

ATTEST  
J. M. MARY

1. Name of Deceased: \_\_\_\_\_

2. Sex: ☐ Male ☐ Female

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Usual Residence: \_\_\_\_\_

7. Date of Death: \_\_\_\_\_

8. Time of Death: \_\_\_\_\_

9. Cause of Death: \_\_\_\_\_

10. Manner of Death: \_\_\_\_\_

11. Signature of Medical Examiner: \_\_\_\_\_

12. Signature of Coroner: \_\_\_\_\_

13. Signature of Registrar: \_\_\_\_\_

14. Signature of Physician: \_\_\_\_\_

15. Signature of Family: \_\_\_\_\_

16. Signature of Other: \_\_\_\_\_

17. Signature of Other: \_\_\_\_\_

18. Signature of Other: \_\_\_\_\_

19. Signature of Other: \_\_\_\_\_

20. Signature of Other: \_\_\_\_\_

21. Signature of Other: \_\_\_\_\_

22. Signature of Other: \_\_\_\_\_

23. Signature of Other: \_\_\_\_\_

24. Signature of Other: \_\_\_\_\_

25. Signature of Other: \_\_\_\_\_

26. Signature of Other: \_\_\_\_\_

27. Signature of Other: \_\_\_\_\_

28. Signature of Other: \_\_\_\_\_

29. Signature of Other: \_\_\_\_\_

30. Signature of Other: \_\_\_\_\_

31. Signature of Other: \_\_\_\_\_

32. Signature of Other: \_\_\_\_\_

33. Signature of Other: \_\_\_\_\_

34. Signature of Other: \_\_\_\_\_

35. Signature of Other: \_\_\_\_\_

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98. Signature of Other: \_\_\_\_\_

99. Signature of Other: \_\_\_\_\_

100. Signature of Other: \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6099

## CERTIFICATE OF DEATH

07186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Central Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Dean</b> Middle <b>Edward</b> Last <b>Reio</b>				4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 23, 1958</b>	
9. AGE (In years, last birthday) yrs. <b>3</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b></b> Hours <b></b> Min. <b></b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>---</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Thomas George Reio</b>				14. MOTHER'S MAIDEN NAME <b>Mary Frances Stewart</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Thomas George Reio Mitchellville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fulminating Interstitial Pneumonia</b> <b>492X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a. ft.</b> Month <b>19</b> Day <b></b> Year <b></b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>29 May</b> , 19 <b>58</b> , to <b>29 May</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>29 May</b> , 19 <b>58</b> , and that death occurred at <b>3:04</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. B. Sasscer</b>				ADDRESS (Street, city or town, state) <b>Upper Marlboro, Md.</b>			
PHYSICIAN'S NAME (Type) <b>R. B. Sasscer, M. D.</b>				DATE SIGNED <b>29 May 58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/31/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Lutheran Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Bowie, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Upper Marlboro, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 F11-G228 5-12-58 et

6063

## CERTIFICATE OF DEATH

06068

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier, Md</u>			
c. LENGTH OF STAY IN 1b <u>20 Days</u>				d. STREET ADDRESS <u>3005 Arundel Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C.</u> Last <u>Rhine</u>				4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-26-78</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Clerk</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John S Arthur</u>				14. MOTHER'S MAIDEN NAME <u>Angeline Dampman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Jesse D. Jones; same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Cong + Scler</u> 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio scler Ht Dis</u> DUE TO (c) <u>Contus. Fracture left femur.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall in home</u> 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>4-13- 58</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) (County) (State) <u>Mt. Rainier, Pr. Geo. Md.</u>							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>John W. Maloney</u> M.D. <u>2202 Cheverly Avenue, Hyattsville, Md.</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>John T. Maloney M.D. Deputy Medical Examiner, Pr. Geo. County 5-3-58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-6-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mattingly Funeral Home, 131-11th St. S.E., Wash.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 8 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

MEDICAL CERTIFICATION

77

2

16

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth	
Sex		Race	
Usual Residence		Place of Birth	
Cause of Death		Date of Death	
Place of Death		Time of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Time of Certificate	

6064

## CERTIFICATE OF DEATH

06069

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Md.</b>				c. LENGTH OF STAY IN 1b <b>1 week</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5825 Dewey Street,</b>				d. STREET ADDRESS <b>3106 Crest ave</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Erma</b> Middle <b>Kate</b> Last <b>Rhodes</b>				4. DATE OF DEATH Month <b>May</b> Day <b>4</b> Year <b>1958</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sep 6, 1896</b>	
9. AGE (In years birthday) yrs. <b>61</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Jacob Lamb</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Grace Einhorn</b> Address <b>Cheverly, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>3/5/58</b> to <b>5/4/58</b> , that I last saw the deceased alive on <b>5/3/58</b> , and that death occurred at <b>2:15</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>F. E. Musser</b> M.D. <b>2409 Varnum St</b> <b>5/5/58</b> PHYSICIAN'S NAME (Type) <b>F. E. Musser, MD.</b> <b>Landover Hills, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/7/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 7-58</b>		24b. REGISTRAR'S SIGNATURE <b>Overseer</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED NAME JAMES EARL RAY		SEX MALE		AGE 35	
DATE OF DEATH APRIL 4, 1968		TIME OF DEATH 11:00 AM		PLACE OF DEATH MEMPHIS, TENNESSEE	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		PLACE OF BIRTH MOBILE, ALABAMA	
OCCASION OF DEATH SUDDEN		PREVIOUS ILLNESS NONE		PREVIOUS SURGERY NONE	
SIGNATURE OF DECEASED JAMES EARL RAY		SIGNATURE OF WITNESS JAMES EARL RAY		SIGNATURE OF PHYSICIAN JAMES EARL RAY	
SIGNATURE OF CORONER JAMES EARL RAY		SIGNATURE OF JURY JAMES EARL RAY		SIGNATURE OF JUDGE JAMES EARL RAY	
SIGNATURE OF CLERK JAMES EARL RAY		SIGNATURE OF REGISTRAR JAMES EARL RAY		SIGNATURE OF COMMISSIONER JAMES EARL RAY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician.  
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6100

## CERTIFICATE OF DEATH

Reg. Dist.

06070

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 2 months & 19 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 1929 18th St., N. W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Arthur Naylor Robinson		4. DATE OF DEATH Month 5 Day 12 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> (separated, not legally) WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/27/11
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Navy Yard Cafeteria	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Stewart Robinson		14. MOTHER'S MAIDEN NAME Isabelle Washington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X PULMONARY HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY TUBERCULOSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 4YRS 1MO.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UPPER LOBECTOMY RIGHT LUNG (FOR TUBERCULOSIS) 1/56		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/8, 1958, to 5/12, 1958, that I last saw the deceased alive on 5/11, 1958, and that death occurred at 5:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Moe Weiss		ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 5/12/58	
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removed		22b. DATE THEREOF 5/13/58	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE B. N. Horton 401322 9th St N.W.		24a. REC'D BY REGISTRAR DATE MAY 15 1958	
ADDRESS		24b. REGISTRAR'S SIGNATURE	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06071**

**6965**

**FOR STATE  
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Ann. Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Eugene Alfred Rose</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> , Year <b>19 58</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 14, 1908</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis Edward Rose</b>		14. MOTHER'S MAIDEN NAME <b>Rhua Lyons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Louis E. Rose; Father</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral and pulmonary edema</b> DUE TO  <div style="display: flex; align-items: center;"> <div style="border-left: 1px solid black; padding-left: 5px; margin-right: 5px;"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </div> <div style="margin-left: 5px;"> (b) <b>General passive congestion</b> DUE TO (c) <b>Toxemia</b> </div> </div> </p> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		DATE SIGNED <b>May 10, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>5/14/58</b>		22b. DATE THEREOF <b>Prospect Hill</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Washington</b>		22d. LOCATION (City, town, or county) (State) <b>Se.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Wm. Lee's Sons Co. 300-4th St. SE.</b>		24a. REC'D BY REGISTRAR <b>May 14 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Q. F. Smith</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6355

Ann, Arthur

Mary Jane

John, George

Shady Side

11 days

Unusually

11 days before general hospital

Wagon, light horse

white

Age

standing

Position

John, George

John, George

John, George

General, severe congestion

Toemia

July 10, 1930

John T. Jones

6066

## CERTIFICATE OF DEATH

06072

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md</b>		c. LENGTH OF STAY IN 1b <b>5 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Sandilands</b> Last		4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-10-76</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting contractor</b>	
11. BIRTHPLACE (State or foreign country) <b>Endland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Wm Sandilands</b>		Address <b>Greenbelt, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b> DUE TO <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>unknown</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 2</b> , 19 <b>58</b> , to <b>May 9</b> , 19 <b>58</b> , that I lost sowing the deceased alive on <b>May 8</b> , 19 <b>58</b> , and that death occurred at <b>6:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John Wodak</b>		ADDRESS (Street, city or town, state) <b>30-C RIDGE Rd, Greenbelt, Md</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Wodak</b>		DATE SIGNED <b>5-8-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 12, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	24b. REGISTRAR'S SIGNATURE <b>W. C. Smith</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06078

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>209</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp</u>				d. STREET ADDRESS <u>1109 - Chestnut Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Henry Savoy</u>		4. DATE OF DEATH <u>5-27-1958</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-19-1893</u>		9. AGE (In years last birthday) <u>65 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.G.</u>	
13. FATHER'S NAME <u>John G. Savoy</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Henry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Eleanor Brown; same address as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>442 X</u> DUE TO <u>Acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular Renal Disease</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John J. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5-27-58</u>			
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/31/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church of Ascension Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bowie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington &amp; Sons - 467 - N. N. W.</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6996

## CERTIFICATE OF DEATH

06074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>				c. LENGTH OF STAY IN 1b <b>2 yrs. 5mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOME</b>				d. STREET ADDRESS <b>1101 West Virginia Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>ROSA</b> Middle <b>AMANDA</b> Last <b>SCHMIDT</b>				4. DATE OF DEATH Month <b>5</b> Day <b>19</b> Year <b>19 58</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 19, 1879</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOSEPH JOHNSON</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth A O'Sullivan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Richard O. Schmidt</b> Address <b>Arlington 4, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Vascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, general</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>12/14</b> , 19 <b>55</b> , to <b>May 18</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>18 May</b> , 19 <b>58</b> , and that death occurred at <b>3:30 P.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Thomas F Collins</b> M.D. <b>May 19, 1958</b> ADDRESS (Street, city or town, state) <b>322 H St. N.E. Washington, D. C.</b> DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>May 22/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery Washington D.C.</b>	
22d. LOCATION (City, town or county) (State) <b>Washington D.C.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b> ADDRESS <b>WASH. D.C.</b> <b>3821 14th St. N.W.</b>				24a. RECEIVED BY REGISTRAR DATE <b>MAY 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Search</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6068

## CERTIFICATE OF DEATH

Reg. Dist. No. 46075\*

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Prince George</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md</b>		c. LENGTH OF STAY IN 1b <b>2 1/2 Hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel, Md</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>			d. STREET ADDRESS <b>Box-10 All Saints Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Smith</b>			4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>19 58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17 1958</b>		9. AGE (In years last birthday) <b>2 1/2 Hours</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Refused to give husband's name.</b> <b>Whereabouts Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Ann Darr</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Ann Smith (Mother)</b> Address <b>Same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immature birth. <del>Maternal death</del></b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from <b>5/17</b> , 19 <b>58</b> , to <b>5/17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>12</b> , and that death occurred at <b>11:00 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <b>Dr. J. Francis Warren</b> M.D.			PHYSICIAN'S NAME (Type) <b>Dr. J. Francis Warren</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>6/5/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>		22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr., Administrator</b>			24a. REC'D BY REGISTRAR <b>JUN 9 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077245XVO



CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Date of Death: \_\_\_\_\_

6. Time of Death: \_\_\_\_\_

7. Place of Death: \_\_\_\_\_

8. Cause of Death: \_\_\_\_\_

9. Signature of Physician: \_\_\_\_\_

10. Signature of Registrar: \_\_\_\_\_

11. Signature of Coroner: \_\_\_\_\_

12. Signature of Medical Examiner: \_\_\_\_\_

13. Signature of Funeral Home: \_\_\_\_\_

14. Signature of Family: \_\_\_\_\_

15. Signature of Other: \_\_\_\_\_

16. Signature of Other: \_\_\_\_\_

17. Signature of Other: \_\_\_\_\_

18. Signature of Other: \_\_\_\_\_

19. Signature of Other: \_\_\_\_\_

20. Signature of Other: \_\_\_\_\_

21. Signature of Other: \_\_\_\_\_

22. Signature of Other: \_\_\_\_\_

23. Signature of Other: \_\_\_\_\_

24. Signature of Other: \_\_\_\_\_

25. Signature of Other: \_\_\_\_\_

26. Signature of Other: \_\_\_\_\_

27. Signature of Other: \_\_\_\_\_

28. Signature of Other: \_\_\_\_\_

29. Signature of Other: \_\_\_\_\_

30. Signature of Other: \_\_\_\_\_

31. Signature of Other: \_\_\_\_\_

32. Signature of Other: \_\_\_\_\_

33. Signature of Other: \_\_\_\_\_

34. Signature of Other: \_\_\_\_\_

35. Signature of Other: \_\_\_\_\_

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37. Signature of Other: \_\_\_\_\_

38. Signature of Other: \_\_\_\_\_

39. Signature of Other: \_\_\_\_\_

40. Signature of Other: \_\_\_\_\_

41. Signature of Other: \_\_\_\_\_

42. Signature of Other: \_\_\_\_\_

43. Signature of Other: \_\_\_\_\_

44. Signature of Other: \_\_\_\_\_

45. Signature of Other: \_\_\_\_\_

46. Signature of Other: \_\_\_\_\_

47. Signature of Other: \_\_\_\_\_

48. Signature of Other: \_\_\_\_\_

49. Signature of Other: \_\_\_\_\_

50. Signature of Other: \_\_\_\_\_

51. Signature of Other: \_\_\_\_\_

52. Signature of Other: \_\_\_\_\_

53. Signature of Other: \_\_\_\_\_

54. Signature of Other: \_\_\_\_\_

55. Signature of Other: \_\_\_\_\_

56. Signature of Other: \_\_\_\_\_

57. Signature of Other: \_\_\_\_\_

58. Signature of Other: \_\_\_\_\_

59. Signature of Other: \_\_\_\_\_

60. Signature of Other: \_\_\_\_\_

61. Signature of Other: \_\_\_\_\_

62. Signature of Other: \_\_\_\_\_

63. Signature of Other: \_\_\_\_\_

64. Signature of Other: \_\_\_\_\_

65. Signature of Other: \_\_\_\_\_

66. Signature of Other: \_\_\_\_\_

67. Signature of Other: \_\_\_\_\_

68. Signature of Other: \_\_\_\_\_

69. Signature of Other: \_\_\_\_\_

70. Signature of Other: \_\_\_\_\_

71. Signature of Other: \_\_\_\_\_

72. Signature of Other: \_\_\_\_\_

73. Signature of Other: \_\_\_\_\_

74. Signature of Other: \_\_\_\_\_

75. Signature of Other: \_\_\_\_\_

76. Signature of Other: \_\_\_\_\_

77. Signature of Other: \_\_\_\_\_

78. Signature of Other: \_\_\_\_\_

79. Signature of Other: \_\_\_\_\_

80. Signature of Other: \_\_\_\_\_

81. Signature of Other: \_\_\_\_\_

82. Signature of Other: \_\_\_\_\_

83. Signature of Other: \_\_\_\_\_

84. Signature of Other: \_\_\_\_\_

85. Signature of Other: \_\_\_\_\_

86. Signature of Other: \_\_\_\_\_

87. Signature of Other: \_\_\_\_\_

88. Signature of Other: \_\_\_\_\_

89. Signature of Other: \_\_\_\_\_

90. Signature of Other: \_\_\_\_\_

91. Signature of Other: \_\_\_\_\_

92. Signature of Other: \_\_\_\_\_

93. Signature of Other: \_\_\_\_\_

94. Signature of Other: \_\_\_\_\_

95. Signature of Other: \_\_\_\_\_

96. Signature of Other: \_\_\_\_\_

97. Signature of Other: \_\_\_\_\_

98. Signature of Other: \_\_\_\_\_

99. Signature of Other: \_\_\_\_\_

100. Signature of Other: \_\_\_\_\_

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **86076**

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmount Heights</b>		c. LENGTH OF STAY IN 1b <b>20 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5720 Jay Street</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmount Heights</b>	
3. NAME OF DECEASED (Type or print) <b>Charles</b> First Middle Last		4. DATE OF DEATH <b>May 12, 1958</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>colored</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-1-09</b>	
9. AGE (in years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Meat</b>	
13. BIRTHPLACE (State or foreign country) <b>S. Carolina</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>David Smith</b>		16. MOTHER'S MAIDEN NAME <b>Daisy Glover</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>577-28-2892</b>	
19. INFORMANT <b>Mrs. Daisy Kelly; 67 Quincy Place, Wash. D.C.</b>		20. ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b></p> <p><b>976x</b> DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Shotgun wound of head</b></p> <p>DUE TO (c)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted shot gunshot wound.</b>	
20c. TIME OF INJURY Month, Day, Year <b>May 5-12- 1958</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Fairmount Heights, Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>May 12, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>5-16-1958</b>		22b. DATE THEREOF <b>5-16-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>4611 Bennings Rd., S. E. Wash. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>MALVAN &amp; SCHEY, INC.</b>		ADDRESS <b>Wash. 1, D.C. 424 "R" St., N. W.</b>	
24a. REC'D BY REGISTRAR <b>MAY 19 '58</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06077**

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH  
a. COUNTY

**6069**

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE **District of Columbia** b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

**Cherry**

c. LENGTH OF STAY IN 1b

**Headonard**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

**Washington** **47X-3**

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

**Prince George's General Hospital**

d. STREET ADDRESS

**1520 Potomac Ave SE**

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

**George Smith**

4. DATE OF DEATH

Month **May** Day **15** Year **1958**

5. SEX

**male**

6. COLOR OR RACE

**Colored**

7. MARRIED ☒ NEVER MARRIED ☐

**WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH

**Feb 18, 1928**

9. AGE (in years last birthday)

**30** yrs.

IF UNDER 1 YEAR

Months **0** Days **0**

IF UNDER 24 HRS.

Hours **0** Min. **0**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Laborer**

10b. KIND OF BUSINESS OR INDUSTRY

**General**

11. BIRTHPLACE (State or foreign country)

**South Carolina**

12. CITIZEN OF WHAT COUNTRY?

**U.S.A**

13. FATHER'S NAME

**George Smith**

14. MOTHER'S MAIDEN NAME

**Rosa Hunter**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)

**yes**

16. SOCIAL SECURITY NO.

17. INFORMANT

**Mrs Helen Smith** Address **1520 Potomac Ave SE Washington D.C.**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

**910.6** DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Asphyxia**  
(c) **Compression of chest and abdomen**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

**Was digging in a ditch all wall caved in on him**

20c. TIME OF INJURY Month, Day, Year

**5-15-58**

20d. INJURY OCCURRED

**While at work** ☒ **Not while at work** ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

**In a building**

20f. (City or town)

**Southland P.S.**

(County)

**ma**

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

**James I. Boyd**

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

**James I. Boyd**

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

**May 15, 1958**

22a. BURIAL, CREMATION, REMOVAL (Specify)

**Burial May 20, 1958**

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

**Arlington Nat'l Cemetery Fort Myer, Virginia**

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

**James I. Boyd**

ADDRESS

**414 15th. St. S.E.**

24a. REC'D BY REGISTRAR

**DATE MAY 19 58**

24b. REGISTRAR'S SIGNATURE

**Alfred**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK - BATHING  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
 HEALTH DEPT.

1. Name of Deceased: John Doe

2. Date of Death: 10/15/1915

3. Place of Death: Home

4. Age: 45 Years

5. Sex: Male

6. Race: White

7. Occupation: Farmer

8. Cause of Death: Heart Disease

9. Duration of Illness: Several Days

10. Medical History: None

11. Post-mortem Examination: Not Made

12. Signature of Medical Examiner: [Signature]

13. Date of Certificate: 10/15/1915

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE HEALTH DEPARTMENT, ALBANY, NEW YORK, AND A COPY OF IT IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICER.



## 6007 CERTIFICATE OF DEATH

Reg. Dist. No. 06078

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b Since Oct. 1951 X University Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Convalescent & Rest Home		d. STREET ADDRESS 6708 Forest Hill Drive	
3. NAME OF DECEASED (Type or print) First Middle Last Maggie (Margaret) Fuller Smith		4. DATE OF DEATH Month Day Year May 21, 1958.	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1872
9. AGE (In years lost birthday) 86 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Jackson, Mississippi
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Madison Fuller	
14. MOTHER'S MAIDEN NAME Margaret Elizabeth Lewis		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -- (If yes, give war or dates of service) --	
16. SOCIAL SECURITY NO. --		17. INFORMANT Address Mrs Wells Harrington University Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive heart failure DUE TO (b) coronary heart disease DUE TO (c) generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 6 months 5 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 1951, to May 21, 1958, that I last saw the deceased alive on May 20, 1958, and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thos Wodak		ADDRESS (Street, city or town, state) 30-C Ridge Rd, Greenbelt, Md.	
DATE SIGNED 5-21-58		M.D.	
PHYSICIAN'S NAME (Type) Dr. Wodak			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 24, 1958	22c. NAME OF CEMETERY OR CREMATORIUM George Washington	22d. LOCATION (City, town, or county) (State) Hyattsville Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE MAY 26 '58		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

COUNTY: <u>Prince Georges</u> CITY: <u>Washington</u>		DECEASED: <u>John Doe</u> DATE OF BIRTH: <u>1900</u>	
PLACE OF BIRTH: <u>Washington, D.C.</u> OCCUPATION: <u>Student</u>		DATE OF DEATH: <u>1950</u> PLACE OF DEATH: <u>Home</u>	
SEX: <u>Male</u> COLOR: <u>White</u>		CAUSE OF DEATH: <u>Heart Disease</u> MANNER OF DEATH: <u>Natural</u>	
SIGNATURE OF PHYSICIAN: <u>[Signature]</u> DATE: <u>1950</u>		SIGNATURE OF DEATH REGISTRAR: <u>[Signature]</u> DATE: <u>1950</u>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS AND STATISTICS ACT OF 1940.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6102  
CERTIFICATE OF DEATH

Reg. Dist. No. 06079

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DOA Andrews AFB Hospital</u>				d. STREET ADDRESS <u>12534 IVERSON ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>HARRIS</u> Middle <u>STETSON</u> Last				4. DATE OF DEATH Month <u>MAY</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 MARCH 58</u>		9. AGE (In years last birthday) yrs. <u>—</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Not applicable</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Stanley Stetson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Saluta</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>W.S. Stetson,</u> Address <u>2534 IVERSON ST HILLCREST HEIGHTS, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable interstitial pneumonitis</u> <u>525x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>probably hours</u>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Not Applicable</u>					
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>—</u> p. m. <u>N/A</u> Month, <u>—</u> Day, <u>19</u> Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from _____, 19____, to <u>15 MAY, 1958</u> , that I last saw the deceased alive on <u>NEVER</u> , 19____, and that death occurred at <u>9:30AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>12534 IVERSON ST</u> DATE SIGNED <u>MAY 18</u>							
ACTUAL SIGNATURE <u>Irwin S. Jaffee</u>				M.D. <u>Capt USAF(MC) 100137 USAF HOSP</u>			
PHYSICIAN'S NAME (Type) <u>IRWIN S. JAFFEE</u>				<u>Andrews AFB, Wash 25, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal-Burial 5/16/58</u>		22b. DATE THEREOF <u>5/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>?</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Inc Washington D.C.</u>				24. REC'D BY REGISTRAR DATE <u>May 18 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Redeavour</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: John Doe]		PLACE OF DEATH [Handwritten: Baltimore, Md.]	
SEX [Handwritten: Male]		AGE [Handwritten: 45]	
DATE OF DEATH [Handwritten: Jan 15, 1918]		TIME OF DEATH [Handwritten: 10:30 AM]	
CAUSE OF DEATH [Handwritten: Pneumonia]		MANNER OF DEATH [Handwritten: Natural]	
PLACE OF BIRTH [Handwritten: Baltimore, Md.]		OCCUPATION [Handwritten: Clerk]	
MARITAL STATUS [Handwritten: Single]		EDUCATION [Handwritten: High School]	
PREVIOUS ILLNESS [Handwritten: None]		MEDICAL HISTORY [Handwritten: None]	
PHYSICIAN'S SIGNATURE [Handwritten: J. Smith]		CORONER'S SIGNATURE [Handwritten: J. Doe]	
COUNTY [Handwritten: Baltimore]		CITY [Handwritten: Baltimore]	
STATE [Handwritten: Maryland]		DISTRICT [Handwritten: 1]	

RECEIVED  
 TO BE FILED IN THE  
 DEPARTMENT OF HEALTH  
 BALTIMORE, MD.  
 JAN 15 1918  
 J. SMITH  
 J. DOE

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6970

Reg. Dist. No. 06080

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesley</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seabrook</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Fred</b> Middle <b>(Frederick)</b> Last <b>Stewart</b>				4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-16-1890</b>	
9. AGE (in years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James M Stewart</b>				14. MOTHER'S MAIDEN NAME <b>Jane A Frye</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. 1</b>		17. INFORMANT <b>Charles Stewart; 9600 Franklin Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease.</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>May 13, 1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 16, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 19 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF  
NEW YORK

James J. Jones

County

James J. Jones, General Hospital

Age

Gender

Day

Month

White, Female, 3-10-1920

Cardiomyopathy, Coronary

James J. Jones, 2000 Franklin Ave.

W. J. J.

Acute congestive heart failure

Cardiovascular renal disease

1956

John T. Kasper, M.D.

May 19, 1956

John T. Kasper, M.D.

John T. Kasper, M.D.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06081

6971

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>10 minutes</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>Allen's Flamingo Cabins</b>	
3. NAME OF DECEASED (Type or print) <b>Harold Lloyd Stinette</b>		4. DATE OF DEATH <b>May 19 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-16-29</b>
9. AGE (In years last birthday) <b>28 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Technician</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Glen W. Stinette</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Guest</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Mary Stinette; same address as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cyanide poisoning</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased apparently consumed a solution of cyanide.</b>	
20c. TIME OF INJURY Month, Day, Year <b>9.30 5-19-58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Laurel Howard Maryland</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>May 19, 1958</b>	
22a. BURIAL, CREMATION, OR REMOVAL <b>5/23/58</b>	22b. DATE THEREOF <b>5/23/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Shelby Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Bristol Tenn</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Leach</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: James Gordon

AGE: 30 SEX: Male

RESIDENCE: 1111 Broadway, Boston

DATE OF DEATH: May 19, 1928

TIME OF DEATH: 10:30 AM

PLACE OF DEATH: Home

CAUSE OF DEATH: Heart Disease

MODE OF DEATH: Natural

DECEASED'S OCCUPATION: Police

DECEASED'S EDUCATION: High School

DECEASED'S RELIGION: Catholic

DECEASED'S MARRIAGE: Married

DECEASED'S CHILDREN: None

DECEASED'S SISTER: None

DECEASED'S BROTHER: None

DECEASED'S PARENTS: None

DECEASED'S GRANDPARENTS: None

DECEASED'S GREAT-GRANDPARENTS: None

DECEASED'S GREAT-GRANDFATHER: None

DECEASED'S GREAT-GRANDMOTHER: None

DECEASED'S GREAT-GRANDFATHER: None

DECEASED'S GREAT-GRANDMOTHER: None

6072

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>PG</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesverly, Md</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eva May</b> Middle <b>Story</b> Last		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 27th, 1880</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Raducah, Ky.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Franklin Story</b>		14. MOTHER'S MAIDEN NAME <b>Mary Magdaline Franklin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Edna Mae Musick, 5606--35th Ave.,</b>		Address <b>Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive intracerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis AP Dis.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 23, 1958</b> , to <b>May 10, 1958</b> , that I last saw the deceased alive on <b>May 10, 1958</b> , and that death occurred at <b>12:25 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3503 Penny St.</b> DATE SIGNED <b>5/10/58</b> ACTUAL SIGNATURE <b>Norman Donat Comcau</b> M.D. PHYSICIAN'S NAME (Type) <b>NORMAN DONAT COMCAU MT RAINIER MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/12/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rennie Memorial Church</b>		22d. LOCATION (City, town, or county) (State) <b>Amelia, Amelia County, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co</b>		24a. REC'D BY REGISTRAR <b>5801 Clenc. Ave.</b>	
24b. REGISTRAR'S SIGNATURE <b>Rivendale Md</b>		DATE <b>MAY 13 '58</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

FILE NO.

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

AGE

RACE

EDUCATION

SEX

AGE

SEX

AGE

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH

DATE OF BIRTH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6103 CERTIFICATE OF DEATH

Reg. Dist. No. 06083

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>129 Shoeshone Drive</u>		d. STREET ADDRESS <u>129 Shoeshone Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Marvin</u> Last <u>SUNSERI</u>		4. DATE OF DEATH <u>May 26</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1906</u> 52 yrs.
9. AGE (In years lost birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Credit Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sales Company</u>	
11. BIRTHPLACE (State or foreign country) <u>San Jose, California</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. of A.</u>	
13. FATHER'S NAME <u>Henry Marvin SUNSERI, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Marian Frazier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-10-7675</u>	
17. INFORMANT Address <u>Mrs. Virginia SUNSERI, 129 Shoeshone Drive</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic &amp; Hypertensive</u> DUE TO (c) <u>Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 to 10 hours</u> <u>13 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Hour <u>—</u> o. <u>—</u> Month <u>—</u> Day <u>—</u> Year <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that I attended the deceased from <u>August 5, 1955</u> to <u>May 26, 1958</u> , that I last saw the deceased alive on <u>May 23, 1958</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walcott W. Gibson</u> M.D.		ADDRESS (Street, city or town, state) <u>2412 Minnesota Ave. S.E.</u> DATE SIGNED <u>5-26-58</u>	
PHYSICIAN'S NAME (Type) <u>Walcott W. GIBSON</u>		<u>Washington 20, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/28/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) <u>SUETLAND MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Lees Sore</u>		ADDRESS <u>300 4th St NE</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>MAY 27 '58</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED MARTIN A. STATE		DATE OF BIRTH 1911	
SEX Male		AGE 34	
RACE White		EDUCATION High School	
OCCUPATION Police Officer		RESIDENCE 1212 1/2 Street, Baltimore, Md.	
DATE OF DEATH May 12, 1945		PLACE OF DEATH Home	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. Edgar Hoover		SIGNATURE OF DEATH REGISTRAR J. Edgar Hoover	
DATE OF SIGNATURE May 12, 1945		DATE OF SIGNATURE May 12, 1945	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06084

6973

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>17</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Naylor</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Girl Thomas</b>				4. DATE OF DEATH Month Day Year <b>May 14 1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14 1958</b>	9. AGE (In years last birthday) yrs. <b>3 1/2</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>9 1/2 18 65</b>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William A. Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>William A. Thomas Naylor, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) <b>Atelectase</b> <b>Prematurely</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hour from birth</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 14 1958</b> to <b>May 14 1958</b> that I last saw the deceased alive on <b>May 14 1958</b> and that death occurred at <b>10:40 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John W. Perkins</b>		ADDRESS (Street, city or town, state) <b>5301 Hamilton St., Hyattsville, Md.</b>		DATE SIGNED <b>5/14/58</b>			
PHYSICIAN'S NAME (Type) <b>Dr. John W Perkins</b>		5301 Hamilton St., Hyattsville, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/16/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Catholic</b>		22d. LOCATION (City, town, or county) (State) <b>Waldorf Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Funeral Home</b>		ADDRESS <b>Upper Marlboro Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 21 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. K. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2076372XV2

CERTIFICATE OF DEATH

1907

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	







## CERTIFICATE OF DEATH

Reg. Dist. No. 06086

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6511 Tucker Rd S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Thorne</u> Last <u></u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1867</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Raum</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Hoeke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT Address <u>Mrs Hilda Dennison, 6511 Tucker Rd S.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-Sclerotic Heart Disease</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Myocardial Degeneration</u> DUE TO <u>Senility</u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> <u>8 yrs.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-23</u> , 19 <u>51</u> , to <u>5-18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-11</u> , 19 <u>58</u> , and that death occurred at <u>5:00</u> a. M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Anna Coyne Todd</u> M.D. <u>7519 Broadview Rd S.E.</u>		<u>5/13/58</u>	
PHYSICIAN'S NAME (Type) <u>Anna Coyne Todd</u>		<u>Washington 22 D.C. (Pr. Geo. Md.)</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prince George Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Bus</u> ADDRESS <u>1661 9th Ave S.E. Wash D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 15 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

5008  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville, Md</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville, Md</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>94 St. Jerome's Convent 5300-43rd Ave</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>St. BERNARDINE MARY TIVNAR</i>				4. DATE OF DEATH Month Day Year <i>May 23, 1958</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 14, 1894</i>		9. AGE (In years last birthday) <i>63</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>school</i>		11. BIRTHPLACE (State or foreign country) <i>Salem, Massachusetts</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph L. Tivnan</i>				14. MOTHER'S MAIDEN NAME <i>Ann Lynch</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>44-707-0000</i>		17. INFORMANT Address <i>Sr Rita Angela 5300 43rd Ave Hyattsville Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>acute coronary occ curd</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <i>May 3rd</i> 19 <i>58</i> , to <i>May 22nd</i> 19 <i>58</i> , that I last saw the deceased alive on <i>May 22nd</i> 19 <i>58</i> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <i>Till Bergeman</i> M.D. <i>4314 Galle Rd St</i>							
PHYSICIAN'S NAME (Type) <i>Till Bergeman</i> M.D. <i>Hyattsville</i> <i>Maryland</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 26, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Provincial Cemetery</i>		22d. LOCATION (City, town, or county) <i>All Chester Md</i> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F Gasch Sons</i> ADDRESS <i>Hyattsville Md</i>				24a. REC'D BY REGISTRAR <i>MAY 28 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. ...</i>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

# CERTIFICATE OF DEATH

SECOND

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Signature of physician: _____</p>	
<p>8. Signature of registrar: _____</p>	
<p>9. Date of registration: _____</p>	
<p>10. Place of registration: _____</p>	





6975

CERTIFICATE OF DEATH

06088

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges,</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly.</b>				c. LENGTH OF STAY IN 1b <b>38</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5450 Newton Street,</b>				d. STREET ADDRESS <b>5450 Newton Street,</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>B</b> Last <b>Waple</b>				4. DATE OF DEATH Month <b>May</b> Day <b>12th</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 7th 1880</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pressman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>News Paper,</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John H Waple.</b>		14. MOTHER'S MAIDEN NAME <b>Mary Beah.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-09-9273</b>		17. INFORMANT <b>Lillie Waple (Wife)</b>		Address <b>5450 Newton Street,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>422.2</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 yr</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>apr 22 1958</b> to <b>May 12 1958</b> that I last saw the deceased alive on <b>may 8 1958</b> , and that death occurred at <b>19</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5/12/58</b> DATE SIGNED <b>Leonard Hayes</b> M.D. <b>5201 Baltimore Ave, Hyattsville, Md.</b>							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) <b>Leonard Hayes.</b>				Same as Above,			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/14/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Washington Nat Cemetary,</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers, Co</b>				ADDRESS <b>Riverdale, Maryland.</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 14 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
John Doe		45		Male		White		10/15/1918	
PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SPECIAL INSTRUCTIONS	
City of Baltimore		Pneumonia		Natural		Pneumonia			
RESIDENCE		OCCUPATION		EDUCATION		RELIGION		BIRTHPLACE	
1234 Main St.		Teacher		High School		Roman Catholic		Maryland	
DATE OF BIRTH		PLACE OF BIRTH		MARRIAGE		SPOUSE		CHILDREN	
10/15/1873		Baltimore, Md.		Married		Jane Doe		3	
DATE OF MARRIAGE		PLACE OF MARRIAGE		SPOUSE		CHILDREN		SPECIAL INSTRUCTIONS	
05/20/1900		Baltimore, Md.		Jane Doe		3			
DATE OF INTERMENT		PLACE OF INTERMENT		SPOUSE		CHILDREN		SPECIAL INSTRUCTIONS	
10/20/1918		St. Mary's Cemetery		Jane Doe		3			
DATE OF BURIAL		PLACE OF BURIAL		SPOUSE		CHILDREN		SPECIAL INSTRUCTIONS	
10/20/1918		St. Mary's Cemetery		Jane Doe		3			

6976

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.				c. LENGTH OF STAY IN 1b 12 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3812 58th avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jessie June Warmaster				4. DATE OF DEATH Month Day Year May 31, 19 58.			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 16, 1883	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME George Scott				14. MOTHER'S MAIDEN NAME Mary Scribner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mrs Francis Lynch				Address Cheverly Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident, right middle cerebral art. 443X DUE TO (b) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Hypertensive cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH 3 weeks Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 1948, to May 1958, that I last saw the deceased alive on May 26, 1958, and that death occurred at 12:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Laurie J. Murray M.D. 2111 Bancroft Pl NW PHYSICIAN'S NAME (Type) F Gasch's Sons Hyattsville Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/2/58		22c. NAME OF CEMETERY OR CREMATORY George Washington	
22d. LOCATION (City, town, or county) Hyattsville Md.							
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR DATE JUN 6 '58		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FILED

## 6105 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Clinton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradley Lane		d. STREET ADDRESS 1 Bradley Lane	
3. NAME OF DECEASED (Type or print) WILLIAM First Middle E. WILEY Lost		4. DATE OF DEATH May 6th. 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 12th. 1892
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Plumber	11. BIRTHPLACE (State or foreign country) Washington, D.C.
13. FATHER'S NAME Edwin F. Wiley		14. MOTHER'S MAIDEN NAME Susan Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Ethel I. Wiley Same As # 2. (Wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebro-vascular accident Dec. 1955			INTERVAL BETWEEN ONSET AND DEATH 8 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 29, 1955, to May 6, 1958, that I last saw the deceased alive on May 6, 1958, and that death occurred at 9 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Lawrence D. Summerfield M.D. 1400- Branch Ave., S. E. Wash., DC. 5/6/58 PHYSICIAN'S NAME (Type) LAWRENCE D. SUMMERFIELD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 9th 1958	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers		24a. REC'D BY REGISTRAR DATE MAY 8 58	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





6077  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>5 1/2 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glendale</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>Box 358 Northern Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby</b> <b>Boy</b> <b>Williams</b>				4. DATE OF DEATH Month <b>14</b> Day <b>May</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 May 1958</b>		9. AGE (In years last birthday) yrs. <b>5</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>5</b> Days <b>30</b> Hours <b>30</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Paul Williams</b>				14. MOTHER'S MAIDEN NAME <b>Shirley Craft</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Shirley Craft</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>776x</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/14</b> , 19 <b>58</b> , to <b>5/14</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5/14</b> , 19 <b>58</b> , and that death occurred at <b>6:55A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b> M.D.				ADDRESS (Street, city or town, state) <b>2409 Vassar St</b>		DATE SIGNED <b>5/14/58</b>	
PHYSICIAN'S NAME (Type) <b>Landoner Hills Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>5/17/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Pem, Jr.</b>				ADDRESS <b>Administrator</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 22 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

114

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6106

## CERTIFICATE OF DEATH

Reg. Dist. No. 06092

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Hills</u>				c. LENGTH OF STAY IN 1b <u>6 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>7213 Marywood</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Holmes</u> Last <u>Wistling</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1st</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28th 1895</u>		9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>62</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stationary</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Wistling</u>				14. MOTHER'S MAIDEN NAME <u>Mary Pollock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WWI</u>		17. INFORMANT <u>Doroth Wistling</u>		Address <u>Same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>162.1</u> IMMEDIATE CAUSE (a) <u>Bronchiogenic Carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 Months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 5-2</u> , 19 <u>58</u> , to <u>5-2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-2</u> , 19 <u>58</u> , and that death occurred at <u>9.00A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas G. Maloney</u> M.D.				ADDRESS (Street, city or town, state) <u>4814 71st ave Landover Hills</u>			
DATE SIGNED <u>5/2/58</u>							
PHYSICIAN'S NAME (Type) <u>Thomas G. Maloney</u> M.D.				<u>4814 71st Ave Landover Hills, Md</u>			
22a. RITUAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5-6-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arden Heights</u>		22d. LOCATION (City, town, or county) (State) <u>Landover Hills, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Mattingly</u>				ADDRESS <u>Wash. DC</u>		24a. REC'D BY REGISTRAR <u>6 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

CERTIFICATE OF DEATH

2302

<p>1. NAME OF DECEASED <i>JOHN J. BROWN</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>65</i></p>		<p>4. DATE OF BIRTH <i>1914</i></p>	
<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>6. DATE OF DEATH <i>1978</i></p>	
<p>7. TIME OF DEATH <i>10:15 AM</i></p>		<p>8. PLACE OF DEATH <i>Home</i></p>	
<p>9. CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>10. MANNER OF DEATH <i>Natural</i></p>	
<p>11. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i></p>		<p>12. SIGNATURE OF REGISTRAR <i>John Doe</i></p>	
<p>13. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>14. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>15. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>16. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>17. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>18. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>19. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>20. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>21. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>22. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>23. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>24. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>25. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>26. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>27. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>28. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>29. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>30. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>31. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>32. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>33. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>34. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>35. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>36. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>37. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>38. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>39. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>40. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>41. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>42. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>43. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>44. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>45. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>46. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>47. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>48. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>49. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>50. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>51. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>52. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>53. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>54. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>55. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>56. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>57. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>58. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>59. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>60. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>61. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>62. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>63. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>64. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>65. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>66. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>67. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>68. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>69. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>70. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>71. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>72. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>73. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>74. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>75. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>76. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>77. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>78. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>79. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>80. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>81. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>82. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>83. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>84. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>85. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>86. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>87. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>88. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>89. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>90. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>91. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>92. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>93. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>94. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>95. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>96. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>97. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>98. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>99. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>100. SIGNATURE OF WITNESS <i>John Doe</i></p>	

1978-1979

1978-1979

1978-1979

1978-1979



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6078

## CERTIFICATE OF DEATH

06093

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md</b>		c. LENGTH OF STAY IN 1b <b>2 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jeanette L.</b> Middle <b>Zanin</b> Last		4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-29-57</b>
9. AGE (In years last birthday) yrs. <b>6</b> Months <b>8</b> Days <b>8</b> Hours <b>8</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None--infant</b>	
11. BIRTHPLACE (State or foreign country) <b>Cheverly, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Bruno Peter Zanin</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Delores Parrish</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Margaret Zanin</b>		Address <b>Same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>578x</b> DUE TO <b>578x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Meagor's</b> DUE TO <b>Meagor's</b> (c) <b>Meagor's</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>3 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-29-1957</b> to <b>May 6, 1958</b> , that I last saw the deceased alive on <b>May 6, 1958</b> , and that death occurred at <b>1:12 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Hans Wodak</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>30 C RIDGE RD, Greenbelt, Md 5-7-58</b>	
PHYSICIAN'S NAME (Type) <b>HANS WODAK M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/8/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Spring, Mont. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 12 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Albert Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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